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ABSTRACT

This report of a joint hearing before the Senate and House Committees on Aging examines elder abuse as a growing problem in America. The testimony considers the benefits of community-based services for the elderly living with relatives, explores other forms of long-term care, and investigates ways to aid victims of elder abuse. An overview of the problem of elder abuse is reviewed in the statements of both witnesses working with victims of elder abuse and actual victims. A description of the legal process, relocation of the victims, and other methods used to resolve the abuse problem are presented. The reluctance of victims to report abuse and their fear of retaliation from abusive relatives are discussed. The appendices contain an overview of elder abuse, a state-wide survey on current protective services, a study of elder abuse in New England, the Model Adult Protective Services Act, and a discussion of suggested legislation. (NRB)

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ELDER ABUSE

JOINT HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

AND THE

SELECT COMMITTEE ON AGING
U.S. HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

WASHINGTON, D.C.

JUNE 11, 1980

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
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ELDER ABUSE

WEDNESDAY, JUNE 11, 1980

U.S. SENATE SPECIAL COMMITTEE ON AGING
AND THE U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON AGING,
Washington, D.C.

The committees met, pursuant to notice, at 10 a.m., in room 2237, Rayburn House Office Building, Congressman Claude Pepper, chairman of the House Select Committee on Aging, and Senator David Pryor, a member of the Senate Special Committee on Aging, presiding.

Present: Senators Chiles, Glenn, Pryor, and Heinz; and Representatives Pepper, Biaggi, Hughes, Evans, Oakar, Lloyd, Gudger, Ferraro, Ratchford, Mica, Stack, Atkinson, Grassley, Hammerschmidt, Marks, Hopkins, and Lungren.

Staff members present from the Senate Special Committee on Aging: E. Bentley Lipscomb, staff director; David A. Rust, minority staff director; Kathleen M. Deignan, research director; Helena G. Sims, professional staff member: Eileen M. Winkelman minority professional staff member; Eugene R. Cummings, printing assistant; and Joan D. Neilubowski and Dianne C. Pearson, clerical assistants.

Staff members present from the Select Committee on Aging: Charles Edwards, chief of staff; Walter Guntharp, minority staff director; Kathleen Gardner, professional staff member; and Marie Brown, executive secretary.

Representative **PEPPER**. The joint committees will come to order, please.

We are fortunate this morning to be able to have the distinguished chairman of our sister committee, as it were, from the Senate Special Committee on Aging to meet with our own Select Committee on Aging of the House of Representatives on the same subject.

Senator Chiles has other engagements that will require him to leave shortly. He has honored us by coming and we are very proud to have him. We are very pleased in Florida to have our distinguished Senator playing a large part in this critical field of trying to help the elderly people of our country. We are proud of the work of his committee.

There will be copresiding today a man who has a long association with the Select Committee on Aging. He was the first House Member to introduce a resolution proposing to set up a Select Committee on Aging. Unfortunately, at that time, he was not able to get the resolution adopted by the House but he set up his own investigating committee and carried on the very interesting and very helpful inquiry into the problems confronting the elderly people of this country. He is a distinguished Senator from the great State of Arkansas, where I had the honor to be a law teacher at the University of Arkansas for 1 year after I graduated from law school. He is today honoring us with his presence. He is an able member of the Senate Special Committee on Aging. I have asked him if he will preside today. I would like to introduce Senator David Pryor of Arkansas who will preside at our hearing.

Senator PRYOR. Thank you, Mr. Chairman. I will have some words to say about you and your involvement in just a moment, but I know that Senator Lawton Chiles of the Senate Special Committee on Aging does have other commitments this morning. He has honored us with his presence and we are extremely proud to have Senator Chiles who I think has a statement at this time. I am proud to be before these two Floridians here who are both chairmen of their respective House and Senate Committees on Aging.

Senator Lawton Chiles.

Representative PEPPER. He represents the hope of getting older, I represent the realization of that hope.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. Congressman Pepper, I want to tell you that the Senate Committee on Aging is very proud to be able to share this hearing with the House Committee. Of course, as you pointed out, in Senator Pryor, we have given you our best leadership to help chair this hearing.

Since I have been a Member of the Senate I have attended many hearings that have focused on unfortunate problems, but perhaps never have I attended one on a problem as regrettable as elder abuse. I wish this was a hearing that we didn't have to conduct. I certainly want to commend you, Congressman Pepper, and Chairman Pryor for having the foresight to move ahead on a delicate issue that studies are telling us needs attention. Even though studies on elder abuse completed so far are mainly preliminary, they are sending us a clear signal that we had better try to do something about this problem now.

The birth rate is down and people are living longer. As a result, there are going to be more older people and more of those older people are going to be living with their children. Adult children may be faced with as many as two sets of grandparents to care for as well as aging parents.

But I think that at the outset we have to be very careful not to misinterpret what the studies are telling us. It should be pointed out that the vast majority of older people who need help are receiving fine care from their families and their friends. Quite simply, I think America cares about its elderly, and families care about their elderly relatives. However, we still know that there is a problem, and that problem seems to be a growing one.

Some researchers have concluded that more community-based services might help families who want to care for elderly relatives at home. Since the delivery of community services and other forms of long-term care are of special interest to me, I look forward to what the witnesses are able to tell us.

I do know that for too long we have shaped too many of our policies in a way that is not favorable for families that want to help themselves by taking care of their elderly and keeping them at home. Our tax policies and everything else are shaped against family care. I think we should do something about it.

I want to thank our panelists, many of whom traveled great distances to share their experiences and their research with us today.

I thank you very much, Mr. Chairman.

Also, Senator Pete V. Domenici, the ranking minority member of the Senate Special Committee on Aging, is unable to be with us today due to prior commitments. He has submitted a statement for the record, which without objection, I will enter into the record at this time.

I thank you very much, Mr. Chairman.

[The statement of Senator Domenici follows:]

Statement of Senator Pete V. Domenici

Good morning. I am pleased to have this opportunity to testify before today's joint hearing of the Senate Special Committee on Aging and the House Select Committee on Aging on the subject of elder abuse. I would like to commend Senator Pryor and Congressman Pepper for their leadership in examining this most important issue.

The high incidence of child and spouse abuse in our society has been relatively well documented. However, the equally scandalous phenomenon of elder abuse—the physical and/or psychological assault upon older persons by family members and caretakers remains largely unexplored and unexposed. Unfortunately though, the syndrome of "the battered elder" appears to be quite prevalent—some studies reveal that it rivals child abuse in frequency where statistics indicate 600,000 cases a year on the average.

The most disturbing thing to me about this situation is the extent to which all forms of domestic violence—child, spouse, and elder abuse—mirror the deteriorating quality of family life in this country. Rising inflation, changing social mores, increases in the rate of marital dissolution, all place incredible strains upon the modern family and these stresses bear a direct relationship to abusive and violent behavior within the family structure. The experts predict that these social strains, coupled with the fact that older people are living longer in family or caretaker situations may result in an increase in the rate of elder abuse in the years ahead. And it is the often frail and dependent elderly person who is least able to cope with and escape from his or her abusive family or caretakers.

I look forward to learning from today's panels of witnesses about the scope of the "battered elder syndrome" and about what steps certain of the States have taken to try to successfully deal with this matter. I thank you for sharing your knowledge and experience with us today. I also want to thank those of you who have been the victims of abuse by your families or caretakers for coming here today and sharing your stories. Although your experiences have not been pleasant ones, the courage you have shown by your willingness to come here today and retell your stories is commendable. It is hoped that the firsthand knowledge you will provide, in addition to exposing the problem more fully, will lead to corrective action so that other older persons will not have to undergo trials similar to those you have experienced.

OPENING STATEMENT BY SENATOR DAVID PRYOR, COPRESIDING

Senator **Pryor**. Mr. Chairman, I have a short statement. I would just like to first say what a pleasure it is for me to cochair this meeting this morning with our very distinguished colleague, Claude Pepper. I think beyond any shadow of a doubt Mr. Pepper has established himself as perhaps the No. 1 leading advocate in the U.S. Congress for the elderly. To this hearing, the first joint hearing that we have had in 4 years, he brings not only extensive knowledge but also extensive commitment to this subject. When dealing with a topic as sensitive and as complex as this one that we will be talking about today, it is good to be able to have the privilege of working with such a capable and dedicated man.

Today, with the help of two highly qualified panels, we are going to explore a very, very complex and emotional issue—elder abuse. Unfortunately, a number of people on this panel this morning know firsthand what elder abuse actually means, they have had that experience themselves. They are the people to whom we will long be indebted because of their willingness to share a personal problem and a personal crisis with this committee and with the Congress and therefore with the country.

I would also like to state that a recent University of Maryland study by Marilyn Block stated that abuse of the elderly is at the stage that child abuse was 20 years ago. I think there are many disturbing questions that have come to mind as we have studied this problem and I suppose, for instance, it is only natural for us to wonder what will happen to us when we grow older, when we get there, when we are no longer working or when we are no longer having children at home, when instead of being the one our family depends upon we may become the one who needs the help.

What happens when we lose that physical and that mental strength? What happens when we no longer have an independent source or financial base? What happens when we no longer have an ability to take care of ourselves? What happens when we reach that greatest of all fears, the fear of abandonment, the fear of dependence, and the fear of having removed from us the right of a personal choice?

These are frightening thoughts, but these are thoughts that we are going to attempt to examine this morning in this hearing panel, the first joint hearing on this particular subject.

Elder abuse may occur as frequently as child abuse. At this point, studies on elder abuse are mainly exploratory, they are by no means conclusive. We still have much to learn and that is exactly why we are here this morning. In fact, let us be honest. We don't even know in many instances the right questions to ask our panel but we are here to learn and we are here to understand the plight of the elderly people in our country who are being abused physically, financially, emotionally, and psychologically. I know that all of us share in our hope that this morning we will find those facts that will enable us to act wisely in coming to grips with this very emotional subject.

I will not read my full prepared statement. Instead, I will place it into the record at this time.

[The prepared statement of Senator Pryor follows:]

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good morning. I must say that I feel fortunate to be cochairing this hearing with my distinguished colleague, Claude Pepper. Beyond any shadow of a doubt, Mr. Pepper has established himself as an able advocate for the elderly. To this hearing—the first joint hearing we've had in 4 years—he brings extensive knowledge in the field of aging. When dealing with a topic as sensitive and as complicated as this one, it is good to have such an able person to work with.

Today, with the help of two highly qualified panels, we will explore the problem of elder abuse. Unfortunately, a number of people on the first panel know about the abuse from firsthand experience. They are people to whom we will long be indebted because of their willingness to share a personal problem with us, in the hope that others might be spared similar traumas. Their unselfishness is certainly admirable.

Many disturbing questions have come to mind as I have studied this problem. I suppose, for instance, that it is only natural for us to wonder what will happen as we grow older—when we are no longer working or when we no longer have children at home; when instead of being the one our family depends upon, we may become the one who needs help.

What happens if we lose our physical strength, or our money, or our ability to take care of ourselves?

These are frightening questions. They have to do with our basic roles in life, and our well-being after a long life of working and caring for others.

Fortunately, as you know Mr. Chairman, most people do not run into serious problems as they grow older. Rather than becoming dependent, they remain self-sufficient and—as members of our committees know—they are usually very effective in their ability to speak out and act on their own behalf.

However, a recent study suggests that elder abuse may occur as frequently as child abuse. On the average, there are 600,000 cases of child abuse a year.

At this point, studies on elder abuse are mainly exploratory. They are by no means conclusive. We still have much to learn. Actually, I'm not even sure that we know what specific questions to ask.

Generally, though, we know that we need to question the appropriate Federal role: What can the Federal Government do to prevent or respond to cases of elder abuse? And, how can we do it without stepping on individual freedoms or States' rights? How can we respond in a responsible way and not be called "big brother?"

I have worked on the elder abuse problem at the State level. While I was Governor of Arkansas, the State's adult protective services law was enacted. Now, several years after the law's enactment, the administrator of Arkansas' program is here to tell us how the State's law is working; what he has learned in implementing the law and what other States might want to think about in deciding how to deal with elder abuse.

I am personally interested in learning more about the likely causes of elder abuse and possible preventive action we might take. Recent studies on the issue seem to indicate that stress contributes to the abuse.

With unemployment and inflation at such high levels, it's certainly no secret that these are stressful times for many people. Child abuse studies tell us that unemployment can be associated with violent behavior. One study found that nearly half of the fathers of abused children were not employed at some point during the year before the abusive act. Twelve percent were unemployed at the actual time of the abusive act.

I have just conducted some hearings on barriers to obtaining mental health services because it is clear that older people are grossly underserved by our Nation's mental health system. Based on what I've learned, I can't help but wonder whether the incidence of elder abuse might be reduced if older people and those caring for them had better access to mental health services that could help them cope with stress.

I also have some questions about the serious legal ramifications of helping an elder abuse victim who either will not or—because they fear reprisals—cannot ask for help. Elder abuse is very different from child abuse in that we are dealing with competent adults. This raises some complicated questions about State protective services laws designed to help abused adults. I am happy to say that we have some expert witnesses who should be able to shine some light on this problem for us.

In short, there are many unanswered questions about elder abuse. Hopefully, this hearing will begin to answer some of these questions and help us determine what the appropriate role of the Federal Government should be in dealing with elder abuse.

Senator **Pryor**. Chairman Pepper.

OPENING STATEMENT BY REPRESENTATIVE CLAUDE PEPPER, COPRESIDING

Representative **Pepper**. Thank you very much, Senator Pryor. I appreciate your kind words. You know what satisfaction it gives me to be working in this critical area with your own distinguished committee. This is another evidence of growing awareness and concern of the American people about the plight of the elderly of this country. They have been neglected too long.

Our committees are primarily investigative committees. We disclose the facts and bring them to the attention of the people and particularly the legislative committees of the House and the Senate. We are hopeful that out of this disclosure of fearful facts will come the recommendations from our committees that can be taken up by the legislative committees and lead to legislation that will immediately help a lot of the people of this country who deserve honor rather than abuse.

As chairman of the House Select Committee on Aging and the former chairman for 4 years of the House Select Committee on Crime, I have found that the most tragic consequence of crime is the fear it imparts in older Americans. Although the elderly fear crime more than any other single problem, they are unlikely to report that they have been abused even by strangers let alone by members of their family.

In an effort to gain a better understanding of the nature and the actual incidence of crime against older people at the hands of members of their own family we have had several hearings by subcommittees of our committee, one of which was held by our distinguished Representative Drinan in Boston and another by the distinguished Representative Biaggi of New York, who is with us today. In those two hearings, those eminent members of our select committee have provided our committee with valuable information.

For example, 500,000 to 2.5 million cases of elder abuse are reported annually in this country.

The elderly suffer from physical beatings and neglect, relocation against their will, emotional and sexual abuse, and financial exploitation.

The majority of victims are single, dependent on their caretaker, politically weak, and lacking in adequate legal protection.

Although the majority of families are doing a good job of caring for their older parents, about 10 percent of all dependent elderly are abused by their families.

Although all 50 States have child protective service laws, only 12 States have such laws for the protection of older persons.

In my own State of Florida, for example, we have had the adult protective service law. I was recently advised that 73 cases of abuse reported in one county of our State from November to April 1980, 49 cases involved abuse of the elderly. I would like to have this Florida county report included in today's hearing record.[1]

In addition to holding hearings, we sent out a questionnaire to the police chiefs of the major cities of the country and we asked them to report what their experience was with respect to abuse of elderly people by members of their own family. The results are not yet complete, but we have preliminary hearings and reports which are shocking. Over 50 percent of the police chiefs responding to our survey acknowledged not only that elder abuse exists but that it is an increasing problem in their respective departments.

The problem of elder abuse has no regional boundaries and occurs nationwide. Much of the elder abuse goes unreported because of the fear of reprisal and embarrassment by the elderly people affected. Inadequate referral resources oftentimes results in lack of intervention, consequently repeated abuses of the victim.

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[1] See appendix, item 1, page 83.

Officers from New York to Minnesota to Dallas were asked to provide examples of cases typically brought to their attention. In Memphis, the police chief reported numerous incidences of elderly abuse including:

> In December 1979 a 70-year-old male and his 65-year-old wife were attacked and fatal injuries were inflicted with a knife.

In Dallas, the chief reported:

> We had a case of an ill, elderly woman who shared a duplex with her middle-aged son. The man was an alcoholic and often opened the house to neighborhood winos. He also sexually abused his mother and drained her bank account. We secured legal assistance and the situation was resolved when the mother was placed in a nursing home and the son was later killed.

In Atlanta, the police chief reports:

> Mrs. M is 60. Mr. B, her son, is 27. She has prosecuted him four times for simple battery of her. He does not work, she is terrified of him and does not let him know where she lives. She also is very worried and concerned that he cannot get ongoing care as an in-patient.

These results, as I said, are preliminary. They indicate elderly persons are the victims of abuse by their own children and that the problem, as the chief says, is growing worse all the time. Congress must, therefore, take note of this situation and appropriately act. Although the Child Abuse Prevention and Treatment Act of 1974 provides for a center to serve as the clearinghouse for certain information on child abuse, no such center exists to collect information on elder abuse. Today, we will hear experts discuss the need for such a center and for legislation to provide funds to those States that develop programs to protect the elderly.

Today, we are looking forward to the testimony of those researchers and State officials who have sought for so long to address this "hidden problem." I refer to elder abuse as a "hidden problem" because for so long it has been just that. But today older persons themselves will discuss, from their own personal experiences, the financial, physical, and emotional assaults they have sustained from their own family. Your testimony will serve to assist hundreds of thousands of older Americans who may some day find themselves similarly situated.

We are pleased to have all of you here with us today and look forward to hearing from you on this important national issue.

Senator **Pryor**. Thank you, Mr. Chairman.

Before we get to our witnesses we have several members of the House committee and also we have at least two members of the Senate committee who might desire to make a statement. Let me ask if we could do this. I address this request respectfully to my colleagues. If you do have an opening statement, I am wondering if we might agree that we could keep each opening statement to 1 minute and then we could allow the balance of that statement, by unanimous consent, to be placed at the appropriate point in the record. If that would be agreeable, then we will adopt that rule. Is that all right with you, Mr. Chairman?

Representative **Pepper**. That is agreeable.

Senator **Pryor**. First, we do have a Member of the Senate who does have to return to the Senate momentarily, Senator John Glenn. Senator Glenn is a member of the Special Committee on Aging.

Senator Glenn, we are proud to have you with us this morning.

STATEMENT BY SENATOR JOHN GLENN

Senator **Glenn**. I think it is important that we keep to this 5-minute rule so we have the maximum time for the witnesses.

Elder abuse is a problem we would all like to pretend does not exist; but we know that this abuse may be as widespread as child abuse. One purpose of today's hearing is to gather information and try to get a handle on what is the nature and the scope of the problem, since it is rather new in coming to public attention. I think we are particularly indebted to the victims of abuse that are willing to come here and willing to share their experiences with us. I know it is not easy for them to retell their stories, but by doing this they are helping to prevent other older people from suffering as they did. We will hear from professionals, including Elizabeth Lau of the Chronic Illness Center in Cleveland, Ohio, about the scope of the problem and about State actions to protect elderly citizens.

Then beyond that we want to determine what, if any, Federal action is needed. I don't know that it is needed, I don't know that it is not. We are here to try to determine what programs can be State programs and what programs can be Federal programs to protect older Americans from abuse and to provide the necessary assistance that will enable families to continue caring for their elderly members.

We had a 1977 General Accounting Office report entitled, "The Well-Being of Older People in Cleveland, Ohio." That city was picked because there are some 118 agencies providing social services in Cleveland. They estimated that as much as 80 percent of the medically related and personal care support received by the chronically limited elderly comes from family and friends. We don't want to have Federal programs or even State programs that disrupt those patterns. We want to help where we can with such programs as respite care, adult day care, home health and counseling, and expand and improve the care family members are willing and able to give their elderly members. This important issue is being considered by our Senate Special Committee on Aging as part of its overall study of long-term care problems of the elderly.

Mr. Chairman, I am sorry, but I do have to go back to the Senate. I do have staff members that will be here during the remainder of the day and they will report to me. I look forward to reading the testimony of those who have come here today. We owe them a special debt in sharing their unpleasant experiences with us.

Senator **Pryor**. Thank you.

Representative **Pepper**. Glad to have you.

Senator **Pryor**. I would like to call on one other Member of the Senate and then, Congressman Pepper, we will call on the Members of the House. We have from the State of Pennsylvania, Senator John Heinz.

John, we are glad to have you and look forward to your comments.

STATEMENT BY SENATOR JOHN HEINZ

Senator **Heinz**. Mr. Chairman, let me commend you and Senator Pepper for holding this hearing. It is indeed shocking to learn of what your committee and our committee has uncovered. In a way, I suppose we should not be totally surprised by what we are finding because any time there is a condition of dependency—whether it is a child, a woman, a patient in a nursing home or a boarding home, an elderly mother or father or a father-in-law or mother-in-law—the conditions of dependency breed a climate that can all too frequently end in the abuse and degradation of a very important human being, the one that is being abused.

I suppose that you might say that it is a terrible embarrassment to all of us to find out what other people are doing to other people. When a daughter-in-law locks somebody in a closet or feeds them dog food, it is a shock. When some father is threatened with poisoning by his son, it is a shock. When a caretaker blackmails an elderly person out of all their life savings, it is a terrible, terrible abuse. We don't want to know about these things because we don't want to really believe they happen. But they do, and those are the family skeletons in the closet that must see the light of day; otherwise, we will never be able to address the problem.

There are, I believe, some ways to address the problem. It is my hope, Messrs. Chairmen, that we will lay the groundwork for more and better ways of helping our elderly to live successfully with more independence and dignity. If we succeed in achieving a consensus and in learning more about the problem, I think we will have furthered the objectives of this hearing.

Again, Messrs. Chairmen—Senator Pryor and Congressman Pepper—and members of the committee, I commend all of you for organizing these hearings. They are very valuable and I am anxious for the promising results.

Senator **Pryor**. Thank you.

Representative **Pepper**. Senator Heinz, we remember when you were an able member of our committee. We are glad to have you back.

Senator **Heinz**. It is nice to be back.

Senator **Pryor**. Mr. Chairman.

Representative **Pepper**. We will next hear from a distinguished member of our committee, Mr. Biaggi, who has done work in this field.

STATEMENT BY REPRESENTATIVE MARIO BIAGGI

Representative **Biaggi**. Thank you very much, Mr. Chairman. I commend you for the joint hearing on this very critical issue. As you stated beforehand, I have chaired an identical hearing in the city of New York. Before I went into the practice of law and came into the Congress, I was a police officer for 23 years and able to view firsthand some of the abuses from child abuse as well as abuse of the elderly. I am sure we will hear some graphic testimony from these witnesses today.

I would like for the record to state the testimony that I heard in one of the most graphic and grievous cases of assault, involving a grandparent and her nephew, in the city of New York. This woman, who was 78 years of age, wheelchair bound, and partly paralyzed, was on several occasions robbed and assaulted by her nephew. To make matters even worse, he sexually abused her on one occasion. On another, he took part of the wheelchair to which she was bound and struck her over the head and body, causing her hospitalization.

This case was a little different, despite her reluctance to testify which is characteristic of the attitude of the elderly. They hesitate because of fear or because of genuine affection for the offender, notwithstanding the assault and terrible injury inflicted upon them. In this case, a neighbor witnessed the assault and together with police authorities, they were able to effect an arrest and prosecute. The culprit is now incarcerated with a sentence of 7 years.

I am certain that this hearing will produce some substantial testimony to warrant legislative and programmatic remedies. There have been a number of studies that indicate that we may have as high as 500,000 instances of abuses. I have some recommendations including legislative changes, that I hope this committee will consider.

The first is to amend the domestic violence legislation to insure that provisions are included to help elderly victims get aid. I observe in the House-Senate conference a resolution to develop final legislation this year and I pledge to work for these important provisions. Second, early considerations of legislation to provide meaningful tax credits for individuals and families providing home care for persons over 65. Third, the early passage of legislation to expand home health care coverage under medicare. Fourth, mandate that the White House Conference on Aging and Families place the issue on their agendas for discussion and specific policy recommendations.

I also urge the adoption of more mandatory reporting laws by the various States. Presently, only 12 States have such laws that mandate reporting. Like child abuse, unless you have a comprehensive and accurate reporting system set up, you never really get the full grasp and depth of the problem.

Later this week, the Subcommittee on Human Services will be releasing a major report entitled "Future Directions for Aging Policy—A Human Service Model." Our report notes the fact that the family will continue to survive as the most desirable providers of care throughout this century during which time a dramatic increase in the elderly population is expected. However, before we all engage in these farsighted policies we must come to grips with the present day horror of abuse.

Thank you very much.

Representative **Pepper**. Thank you very much, Mr. Biaggi.

Mr. Hammerschmidt of Arkansas.

STATEMENT BY REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Representative **Hammerschmidt**. Thank you, Mr. Chairman.

I do have a very short statement. I will be brief.

Before I begin my statement, I want to thank you for holding these hearings, along with the very distinguished Senator Pryor of Arkansas. David and I came to Congress together in 1967, and as you said, there would not be the Select Committee in the House if it was not for his missionary work when he was over here on the House side. I feel honored to be on a committee that he is chairing this morning.

Last week, this committee held a hearing on the elderly and the family and Elaine Brody said that most families are very responsible in their care of elderly family members. She also added that elderly abuse is not at all a common condition, but instead an example of psychopathology. The vast majority of researchers in gerontology in the 1977 GAO home health report state that most of the community support for the elderly is supplied by the family.

Now I want to make these observations. When we discuss the issue of elder abuse, we see it as an aberration in the broad pattern of adequate family care. If we do not make a concerted effort to keep it in perspective, elder abuse can appear to be far more pervasive than it is. Whatever the number of victims, the issue is a serious one and does demand our attention.

One other personal observation. We do have a witness here from Arkansas, who I am sure is going to receive a proper introduction later from our distinguished chairman, but I will mention Bryan Tilley, legal services developer, Office of Aging, in my own State of Arkansas. Our State is one of the 12 States with an adult protective service law. I may have to leave to go to a subcommittee hearing, so I wanted to make that personal observation and my thanks to Mr. Tilley for being here.

Representative **Pepper**. Thank you.

Mrs. Oakar of Ohio.

STATEMENT BY REPRESENTATIVE MARY ROSE OAKAR

Representative **Oakar**. Thank you, Mr. Chairman.

Mr. Chairman, Senator Pryor, I appreciate the fact that both of you have called this meeting today.

Mr. Chairman, as you know, today I am introducing a bill that provides a partial solution to the problem that we are focusing on today. The bill is called the Adult Abuse Prevention/Treatment Act and it would provide recourse equal to that provided for children under 18 who suffer abuse.

It really is a national disgrace that we have a child abuse law but we do not have an adult abuse law. I am not just talking about the older Americans, I am talking about the handicapped, mentally retarded, battered women, and so forth.

Mr. Chairman, one of the things that I don't think has been mentioned is that many people who are in a position to report abuse are not protected by the law. We have had in our own office, for example, individuals who will call our office, like the aide who worked in a nursing home, who knew that another employee had raped a 96-year-woman, and she wanted to do something about it, but the law did not protect her. Our bill would make it mandatory to report such activities and provide immunity from legal recourse for the individual.

So we are very, very happy that this hearing is being held today. We are hoping, Mr. Chairman, that others will cosponsor the bill that I am introducing today, as you have cosponsored it, and I am very, very appreciative of that fact.

I do want to make mention of an individual from Cleveland, Ohio, who is here today, Elizabeth Lau, who is with the Chronic Illness

Center in Greater Cleveland. She, along with Kathy Gardner on your staff, Mr. Chairman, and my own staff member, Carol Miller, who has a masters in gerontological nursing, have been very, very helpful in putting together the research necessary to provide for this legislation. The time is now for this kind of legislation. I think, personally, we do know enough about the problem to at least have this kind of legislation introduced and passed.

Mr. Chairman, I do want to submit a full statement for the record along with a copy of the legislation.[1]

Representative **Pepper**. Without objection, it will be received.

[The prepared statement of Representative Oakar follows:]

Prepared Statement of Representative Mary Rose Oakar

Senator Pepper and Senator Pryor, I want to personally thank you for holding this hearing concerning the pervasive problem of elder abuse.

This subject has been a major concern of mine for almost 2 years and our office has done considerable research to arrive at legislative solutions to this most serious national problem. Although we have evidence that abuse of the elderly is a harsh reality for an estimated 1 million older Americans, unfortunately there are few scientific studies which document the extent of this problem. One major study often cited was done in my area of Cleveland, Ohio. This study, carried out by the Chronic Illness Center and Case Western Reserve University, showed evidence of abuse in 10 percent of the cases of people over 60 years old who were served by the Chronic Illness Center. Betty Lau, a protective services worker and one of the authors of this study, will be testifying later today at this hearing and will give details of this study.

Previous congressional hearings have heard testimonies which document innumerable reports of adults in nursing homes and mental institutions who have been burned, sexually assaulted, beaten and have even died as a result of mistreatment and neglect. Nor is it just the institutionalized vulnerable adults who are often the victims of abuse—older persons living with relatives and other caretakers are often abused, neglected, and exploited.

In my own congressional office, we have received reports of abuse, neglect, and exploitation of the elderly. One particular example is that of an 81-year-old woman who was brought to a local emergency room with severe head injuries and a fractured skull. This woman had lived with her daughter and son-in-law for 5 years, and the family had experienced much stress as a result of caring for this older family member over a long period of time without any community supports. The family reported that the woman had fallen out of bed and sustained the injuries. However, the doctor in the emergency room requested social service intervention because he strongly suspected abuse. The doctor had even taken photographs of the woman when she was admitted to the hospital, anticipating that he might need these as evidence when the case was investigated. The social worker called protective service requesting an investigation and assistance, but was told that since there are no laws in Ohio requiring that suspected cases of abuse be reported and investigated, there was nothing that could be done for this woman. In another instance, an aide of a nursing home reported to our office that a 96-year-old patient was raped by another employee. These cases reflect the situation of thousands of other older Americans, however, currently there is no law to provide the protection and legal recourse needed by these victims of abuse, neglect, and exploitation. Today, I am introducing a bill, which I'm happy to say is cosponsored by Senator Claude Pepper, which will provide protective services and legal recourse equal to those provided for children under 18 who suffer abuse.

The "Adult Abuse Prevention and Treatment Act" which we are introducing today, will create a National Center on Adult Abuse and will provide money to States for adult abuse prevention and treatment program. In order to qualify for these funds, States must have in effect an adult abuse, neglect, and exploitation law which provides for mandatory reporting and immunity for persons reporting instances of abuse, neglect, and exploitation. Upon receipt of such a report, States must initiate an investigation and take steps to protect those abused, neglected,

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[1] See appendix, item 2, page 84.

or exploited adults. Furthermore, States must have in effect administrative procedures, trained personnel, institutional, and other facilities, and multidisciplinary programs to deal effectively with these special problems. Additionally, States must provide for the cooperation of law enforcement officials, courts, and appropriate agencies providing human services, with respect to these problems of adult abuse, neglect, and exploitation. Also included in this bill is the provision that States must provide that the abused, neglected, or exploited adult participate in decisions regarding his/her welfare, and provide that the least restrictive alternatives be made available to the abused, neglected, or exploited person. Lastly, information about the programs and special problems of adult abuse, neglect, and exploitation must be disseminated.

This bill will relate not only to the elderly who are often the victims of abuse, neglect, and exploitation, but also to other vulnerable adults such as women and the mentally and physically handicapped. It is long overdue that the millions of elderly and handicapped persons who are the victims of abuse and neglect be provided the services and protection to which they are entitled. The deliberate abuse of individuals who are least able to protect themselves is a national disgrace. We are hopeful that the "Adult Abuse Prevention and Treatment Act" will provide the viable solutions to meet the critical problems of vulnerable adults who suffer abuse, neglect, and exploitation.

Again, thank you for the opportunity to participate in this hearing. I am submitting for the record a summary of this bill along with a copy of the bill which is being introduced today.

Representative PEPPER. Thank you very much, Mrs. Oakar.

Mr. Grassley.

STATEMENT BY REPRESENTATIVE CHARLES E. GRASSLEY

Representative GRASSLEY. Thank you, Mr. Chairman.

I appreciate the opportunity to meet with our Senate colleagues in a joint hearing on this important topic, and I thank you for your leadership in this area.

At some point in the process of aging, most of us reach the point where we are dependent on others. Such dependence may be due to financial need or failing health, or it may be the only alternative to loneliness. In all events, it is a condition that none of us can escape once we reach a point where we lack the physical, mental, or financial resources to maintain our independence.

For the more fortunate of us, dependence in old age is softened by the love and companionship of a family home or by an institution where treatment of the elderly is thoughtful and compassionate. Recent data suggests, however, that many of the dependent elderly receive anything but love and compassionate care. Children abuse their parents; institutions for the elderly abuse their clients. The outrages against these helpless elderly include physical beatings, oversedation, induced alcoholism, starvation, the withholding of medication, verbal abuse, and hostility.

The extent of such callous and inhumane treatment is not yet well documented, but there are indications that it may be of much broader scope than was suspected a few years ago.

I know that I am joined by my colleagues on the committee in hoping that this hearing will add to our knowledge of this appalling situation and that the testimony we hear will give us a basis for any investigative or legislative action that might be appropriate.

Representative PEPPER. Thank you very much, Mr. Grassley.

We will next hear from my own distinguished colleague, Mr. Stack of Florida.

STATEMENT BY REPRESENTATIVE EDWARD J. STACK

Representative STACK. Thank you, Mr. Chairman.

Beyond commending you and Senator Pryor for initiating this effort today, I would withhold any statement at this time in the interest of getting on with hearing from the panel, which is our major mission for being here.

Representative PEPPER. Thank you, Mr. Stack.

Mr. Marks of Pennsylvania.

STATEMENT BY REPRESENTATIVE MARC L. MARKS

Representative MARKS. Thank you, Mr. Chairman.

Mr. Chairman, may I also, with my colleagues, say thank you to both you and Senator Pryor for convening these hearings today on what is a very important problem, abuse of the elderly. This will, I believe, turn out to be a much more widespread problem than many now realize. In my own State of Pennsylvania, the Department of Aging has made this a top priority.

One of the problems that the State discovered is that there are no figures available as to the dimensions of this problem. Consequently, the Pennsylvania Department of Aging is in the final process of developing a questionnaire which will be going to a large sample of doctors, police officers, and social workers so we will be able to know the extent and the seriousness of elderly abuse in the Commonwealth of Pennsylvania.

Mr. Chairman, I believe quite strongly that we must do more in this country to encourage multigenerational families to live together. Grandparents have an immeasurable amount of benefit to offer their children and grandchildren and vice versa. I believe you would see fewer problems among the youth of today if there were more grandparents at home, available to help, to be there, to counsel, and to console. Unfortunately, many laws and regulations today provide a disincentive for extended families to stay together.

If there are strong financial disincentives for an elderly person to live with their children, that adds to the tension in a family and makes it more likely that there will be some sort of abuse of the elderly person—stemming from frustration or resentment. Some examples of laws that we can and should correct to encourage families to care for their elderly parents themselves are:

There is now a large deduction in SSI benefits that an elderly person receives if he moves in with his or her children.

Medicare and medicaid do not reimburse many of the medical costs incurred if an elderly person lives with his or her family that are reimbursed if he or she lives in a nursing home.

There is no Federal subsidy or tax benefit to reimburse the family for the costs of someone to take care of an elderly person living with his or her family—and yet these costs will be borne by the Government if the elderly person moves into a nursing home.

We give a tax credit for a working parent for child care costs, and yet we give no tax credit for working parents who want to take care of an elderly person.

If changes must be made in a family's home to accommodate an elderly person who wants to move in—such as adding a bathroom or a bedroom on the first floor—not only are there no tax credits to help subsidize these costs, but the family's property taxes will go up because the property has been improved.

These are just a few examples of the kinds of changes we, as legislators, should be looking into. I think that if we can create financial incentives—instead of the current counterproductive financial disincentives which now exist—that more extended families will find it easier to live together with less tension. I think that would truly be of benefit for all the generations involved.

May I add just one other thing. Despite my gray hair and patch on my forehead, I was not abused.

Representative **Pepper**. Thank you very much, Mr. Marks.

Mr. Evans of Indiana.

STATEMENT BY REPRESENTATIVE DAVID W. EVANS

Representative **Evans**. Thank you, Mr. Chairman.

I thank you for convening the hearing today. It is a very important hearing and I look forward to hearing from our witnesses.

Thank you.

Representative **Pepper**. Thank you, Mr. Evans.

Mr. Gudger.

STATEMENT BY REPRESENTATIVE LAMAR GUDGER

Representative **Gudger**. Thank you, Mr. Chairman.

Chairman Pepper, Senator Pryor, I want to join you in welcoming these witnesses today who are so generously giving their knowledge and expertise in this field. With their help, I am pleased that the committee will be examining the factors that contribute to the abuse of the elderly. Hopefully, we will discover how widespread this abuse is and will evolve methods whereby something can be done to eliminate it. It is an area requiring immediate attention and I congratulate the chairman here for addressing the problem promptly.

I take special interest in problems associated with the aging because in my district in North Carolina about a quarter of our population is 55 or older and 1 in 19 is 60 or older. I am in the 1 in 19 group who is 60 or older.

I am confident that the hearings today are going to be important to my State, to each of your States, Mr. Chairman, and to all of the States as we get into this problem, find out what it consists of and what we, in the Congress, can do about it.

Thank you very much.

Representative **Pepper**. Thank you, Mr. Gudger.

Mr. Lungren of California.

STATEMENT BY REPRESENTATIVE DON LUNGREN

Representative **Lungren**. Mr. Chairman, I would also like to echo the comments of my colleagues about how urgent this particular issue is. I salute you and Senator Pryor for having these hearings.

Frankly, I don't want to take any more time. I would like to hear the witnesses go forward.

Representative **Pepper**. That is very kind of you. Thank you, Mr. Lungren.

Mr. Lloyd of California.

STATEMENT BY REPRESENTATIVE JIM LLOYD

Representative Lloyd. I echo the Chairman's statements. I would like to submit a statement for the record.

Representative Pepper. Your statement will be made a part of the record.

Representative Lloyd. Thank you, Mr. Chairman.

[The statement of Representative Lloyd follows:]

Statement of Representative Jim Lloyd

Mr. Chairman, I commend you for calling this hearing to focus attention on the serious problem of elder abuse. It is very difficult to bring ourselves to explore a problem which is unpleasant, involves individual lives and relationships, and in so many respects—including personally and legally—is very sensitive to deal with.

However, our society has a responsibility to cope with this social ill and to protect those who either cannot, or possibly for reasons of fear, shame, or dependence will not, protect themselves. Elder abuse is just one aspect of mistreatment within the family, such as child abuse and spouse abuse. Each of these has been brought to public light, and some legislation has resulted. However, I think it would behoove us to take a closer look at the possible correlation between these problems in order to better understand what we are faced with and to deal with it comprehensively.

I strongly support legislation which would provide a broad range of services—social, legal, and educational—to protect and care for victims, as well as try to relieve the problems or stresses within the family which precipitated the abuse. This must, however, be based on more extensive research into the causes of abuse within the family. Increased understanding is also fundamental to efforts at prevention, which should be our ultimate goal. No individual, child or adult, should have to suffer in silence because there was nowhere to turn for help.

Representative Pepper. Mr. Hughes of New Jersey.

STATEMENT BY REPRESENTATIVE WILLIAM J. HUGHES

Representative Hughes. I commend you, Mr. Chairman, and Senator Pryor for convening this hearing and I am anxious to hear the witnesses.

Thank you, Mr. Chairman.

Representative Pepper. Thank you very much. Senator Pryor.

Senator Pryor. Ladies and gentlemen, with the permission of the other members of the committee, I am going to impose a no smoking rule. If you desire to smoke, we ask that you go outside in the hall.

Our first panel this morning is going to be comprised of older persons. Some of these individuals do not talk very loud so we are going to have to pay very careful attention.

Our first witness this morning is Mrs. X. Mrs. X is from Massachusetts and she is going to relate her own personal experience.

Ms. Collins. Mr. Chairman, the witness asks that she not be photographed; that is why she is wearing sunglasses and a hat.

Mrs. X. I asked to be anonymous.

Ms. Collins. There will be reprisals against her.

Representative Pepper. Very well. Will the media please honor the request of these witnesses who request not to be photographed. They have their own reasons for not wanting to be photographed. Will the media please be kind enough to honor those requests. Mrs. X prefers not to be photographed.

Senator **Pryor.** Mrs. X is accompanied by Merrillyn Collins who is her protective service worker of the Minuteman Home Care Corp., Lexington, Mass. Also accompanying Mrs. X is James Bergman who is project director of the Legal Research and Services for the Elderly in Boston. He helped conduct a study on elder abuse in Massachusetts, which surveyed professionals and paraprofessionals. He found that 70 percent of those responding to the survey indicated that incidents of abuse tend to be recurring events and not single occurrences.

We are proud to have Mrs. X appear today. If I could, I would like at this time to ask Ms. Collins and Mr. Bergman if they would please assist the witness in her testimony.

Ms. **Collins.** Mr. Chairman, Mrs. X just requested that I mention that the press can photograph her provided they put a flyer over her face to make sure she can't be recognized.

STATEMENT OF MRS. X, 79, OF MASSACHUSETTS, ACCOMPANIED BY MERRILLYN COLLINS, PROTECTIVE SERVICE WORKER, MINUTEMAN HOME CARE CORP., LEXINGTON, MASS., AND JAMES BERGMAN, DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, BOSTON, MASS.

Mrs. X. My name is Mrs. X and I would like to tell you my story in the hopes that others will be helped by my experience with this problem.

My husband died 10 years ago. The house where we lived became mine, exclusively, furnishings and other materials included. My younger daughter, who had two unfortunate marriages, was welcomed by us and helped in every way we could with her and her children. This began over 18 years ago. The past 3 years, things have gotten steadily worse. My daughter locked me in the garage and left me there for more than an hour. She always parked her car behind mine in the garage so I could not get my car out except by her permission. She insisted upon a weekly time schedule of when I wanted my car in or out of the garage and she would become very upset whenever I changed the schedule.

One morning she told me I could not use the bathroom or the kitchen any more. I called the Mental Health Association immediately and reported this. The doctor there called my daughter, and, whatever transpired, being barred was never mentioned again.

Whenever I tried to cook a meal she would appear and turn the gas off and remove the grills so the only way I could cook was to hold the pan the right distance over the flame. Also, if she found me using the electric toaster oven, my food was thrown on the floor and the toaster oven was removed and hidden for several days. She posted a time schedule on the kitchen door as to when I could use the kitchen and the time allowed me was too short to cook a meal.

During the winter months, the temperature in my bedroom was between 52° and 64°. I had an electric heater, but during freezing temperatures outdoors my room never seemed to get warm enough for any length of time. I had to keep my room locked at all times for fear of what she would do to the contents if she got in. Once she got in, I would find things missing. Several times she locked me out of the house. One of those times it was very cold and snowing with ice on the ground. I had to get to a pay station to call a friend to come and get me. My daughter's treatment of me kept getting worse. Always hurting me physically and mentally; kicking me, pushing me, grappling with me, telling me to get out, at one time throwing a drawer down the stairs at me, calling me names, telling me I belonged in a nursing home and why didn't I go to one. I was not included in family festivities for any of the holidays. She told me I was senile and paranoid and my brain was all shriveled up.

Fairly recently she knocked me down and I hurt my back. I called the Mental Health Association and they told me to go to the hospital immediately for examinations, which I did. Upon leaving the emergency room I was met by a very nice young lady who turned out to be my protective counselor, Merrillyn Collins, who is here with me today. We talked about many angles of my case. She advised me to apply for a restraining order. She offered to go back to the house with me along with a policeman to make sure it was safe for me to stay there. A few weeks later, when things got much, much worse, I went to court and obtained the restraining order which I have with me at all times.

I was warned many times to get out of the house by my doctor, my lawyer, my protective counselor, and my adviser at the Mental Health Association. My other daughter, who lives in another State, and has been so strong, so helpful, so loving and always praying for my safety, felt the same way. They all knew my life was in danger while staying under the same roof with this emotionally very sick 45-year-old person. She is a well-educated woman, having graduated from college, continued in graduate school and got a masters degree in no less than social service. Upon learning the children were being brainwashed, I did leave my house and in a hurry. I applied at the house-sharing program for a place to live. The next day they had a place for me, and with a lady I had known and admired for some time. Now I am very happily situated.

This is just a small bit of what has been going on for the past 3 years. I am very grateful for the services available to me during this trying time: The Minuteman Home Care Corp., the protective services counselor, the Housing Aid for Senior Citizens. A force within me is reaching out, wanting to help any cruelly abused elderly person, and that is why I am here today. I am also here to appeal to the committee to continue the necessary funding for the services I just mentioned. I am very grateful to this committee for allowing me to tell my story, and I only hope and pray that others will be helped by it.

Thank you very much.

Senator **Pryor**. Mr. Bergman, I believe that you have a short statement to follow that of Mrs. X.

STATEMENT OF JAMES BERGMAN, DIRECTOR, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, BOSTON, MASS.

Mr. **Bergman**. Thank you, Mr. Chairman.

It is a pleasure to be here today, although it is never a pleasure to talk about this subject. Slightly less than a year ago, a hearing on elder abuse was held in Boston. We had the honor of working with the House Select Committee on Aging and with Representative Drinan on that hearing. I believe that was the first congressional hearing held on this subject. At that time, much had happened but not much had been reported about elder abuse. Within the past year, an enormous amount of attention has been given to this issue.

In our case, we have worked for passage of mandatory reporting legislation, which in Massachusetts, we have trained over 400 workers in how to handle elder abuse cases; and we have also participated in handling approximately 50 of these cases ourselves, including the case of Mrs. X. Our work in the area of elder abuse in the past 12 months has more or less confirmed the findings of our statewide survey in Massachusetts, which were reported to the House Select Committee on Aging at the Boston hearing last June 23.

Significantly, our surveys showed that the initial reporters were very rarely the actual victims. In the case of Mrs. X, the report came in not from Mrs. X, but from a Greater Boston home care corporation. In only about 24 percent of the cases that we found in our Massachusetts survey was the actual victim the initial reporter of the problem. Of the approximately 50 cases we have handled in the last year, less than one-quarter of those cases came directly from the victim. We think this is very typical.

Normally, reports of elder abuse come in from family members, from friends, from neighbors, or from other social service agencies. Frequently, the report comes in saying: Please don't do anything to involve us, we just want you to know about the problem. Would you please go out and do something now to help.

Such a report is not a very big help. It almost assuredly denies the agency contacted access to the client because the reporter is not prepared to assist in providing access to the alleged victim. Many times, the report is as far as the agency can go in these cases. Second, even if access is gained, frequently the victim, unlike Mrs. X, does not desire to do anything about it. Fortunately in Mrs. X's case, she agreed to take legal action and got a restraining order. That is a very, very rare case indeed, from our experience.

One of the significant results of our survey and also of the 50 cases is that they, in grisly detail, confirm that physical battering is very frequently a part of elderly abuse. Deaths were not reported in our initial survey, but of the 50 cases we have handled in the past year, we are certain that in at least 2 of those cases deaths did result from the elder abuse. This, I think, is quite significant. It suggests to us that, just as in child abuse cases, we are going to find more and more deaths reported in elder abuse cases.

One of the cases that resulted in a death involved a grandson who shot his grandmother and then apparently to cover up the crime, burned the house down. It was only when the medical examiner examined the remains of the victim that he found the gunshot wound. A district attorney in Massachusetts is now prosecuting that case under a criminal indictment.

The second case was one which I think is even more typical. A hospital social worker called us within minutes of a 92-year-old woman being admitted to the emergency room. She had been severely beaten, severely bruised, and had a skull fracture as well. The hospital worker wanted to know two things: One, was there anyone that they had to report this to; and, two, if they did report it, what was the hospital's potential liability. For example, would the hospital be liable for slander if they alleged the son and daughter-in-law had been the ones who had beaten this woman? Those were their two major concerns.

We suggested that they talk to their own legal counsel. We also gave them our advice on the situation and had almost daily contact for a week with the hospital worker on this case. At the end of that week the victim died. At the end of that week also the hospital had concluded that there had not been physical abuse; there had not been the sexual abuse they originally reported had been there; and that this woman, who was bedridden, had, in fact, gotten the bruises by falling out of bed.

On the second day after the woman was admitted the hospital worker and staff confronted the son and daughter-in-law and told them that they were convinced that the woman had been beaten. The son and daughter-in-law denied it hysterically. Interestingly, at the time of the victim's death, the hospital record did not show any evidence that there might have been abuse. Was it abuse or was it someone falling out of bed? In our opinion, it was absue. The hospital, however, would have been open to a possible slander charge if they had alleged the son and daughter-in-law had beaten her.

I think this makes it more clear than any other example that I can cite that there is a great need for mandatory reporting laws and ones which give immunity to reporters. Without immunity from suits, many of these cases of elder abuse, including those in which death results, are not going to be reported any more than they were in child-abuse cases. I would respectfully suggest, Mr. Chairman, that Congress consider changing the title XX social services program in such a way that it encourages States to set up protective services programs for the elderly and encourages mandatory law.

Also, reechoing Mr. Biaggi's comments, I would encourage the House to accept the Senate version of the Domestic Violence Act. This would allow older persons to benefit from the act even if the abuser were not a spouse.

Finally, I would ask that the committees strongly encourage the Administration on Aging to devote more research and development money to programs which produce more research on elder abuse and which establish regional elder abuse centers to deal with the issue, as the chairman has suggested.

Thank you.

Representative Pepper. The next on our first panel is Mr. Y of the District of Columbia, accompanied by Dolores Roberts, his adult protective service worker, followed by Mrs. Z of California, who is accompanied by her adult protective worker, Marsha Standley.

Dr. Suzanne Steinmetz will act as the panel coordinator. She is a professor in the Department of Individual and Family Studies at the University of Delaware. She is an expert in the area of elder abuse and is currently involved in research on the extent of abuse in her State. She was a coinvestigator of a National Institute of Mental Health grant to study violence in American families.

Dr. Steinmetz has testified before the House Aging Committee on previous occasions on the issue of domestic violence. Today she will provide the committee with an overview of the problem and give an estimate of the incidence and theories as to why this abuse takes place.

We will be pleased to have Mr. Y now proceed with his statement.

Mrs. **Roberts**. Excuse me. Mr. Y said he would like to be called by his name, which is Mr. Jones.

Representative **Pepper**. Very well.

Mr. Jones, we appreciate your being here with us today and we welcome your statement.

STATEMENT OF WILLIAM JONES, WASHINGTON, D.C.

Mr. **Jones**. I am William Jones. Five years after my wife's death I had to get help to take care of my financial affairs because I could not make the checks out. My son, Milton Jones, interfered and wanted to have his name put on my checkbook, so I had to have Blake's name taken off and his name put on, and by that way he wanted to take all my money from me. I decided that I would do that, and so by doing so, he began to not give me any money and I didn't have a chance to get anything to eat.

I finally called around to my cousin and she got hold of the protective service and so they happened to come by and take me out. Before then, I only had one meal a day and I had to live off greens and turkey wings all the week, and the next week was chicken wings and noodles, which had maggots in them, they finally got sour. I had to fend for myself.

They asked me where would I go, so I called my cousin and she told me to come out there. In the meantime, before then, my son shoved me over a chair and told me that he was not going to do anything for me. I told him I was human, don't be doing that to me. He said he didn't care. Finally, I had to leave anyway, so that was all I know.

Representative **Pepper**. Mrs. Roberts, do you have anything to add to the statement of Mr. Jones?

Mrs. **Roberts**. Yes; I do.

Representative **Pepper**. Please go ahead.

STATEMENT OF DELORES M. ROBERTS, WASHINGTON, D.C., ADULT PROTECTIVE SERVICE WORKER

Mrs. **Roberts**. As Mr. Jones stated, he came to our attention through a cousin of the family who stated that he was being exploited, abused, and neglected. When I went out initially to see Mr. Jones, he was very fearful and was reluctant to let me into his home. When I did enter the home, the home was filthy; it was infested with mice and roaches.

He also showed me the guns. He had seven guns in his house, where his son had threatened to use them on him if he let anyone come into the house. The mail in the house was stacked so high because the son did not allow him to open his mail. Not only that, but he did in fact push his father around. Also, he would not allow him his moneys from a passbook savings account that he had in the bank. The day I was there, he showed me $7 that he had been saving for months. He said that just in case an emergency would happen to him he would have at least the $7.

Mr. Jones' retirement checks were mailed directly to his bank and placed into his account, but all the withdrawing was done by the son. What we did, I had the bank put a red tag on his passbook to close off his account until we were able to go down to the corporation counsel's office and take out a protective order on the son. After we did that, we removed Mr. Jones from his home to a relative that kept him for a short period of time, until we were able to find placement for him.

Mr. Jones went to court. Of course, his son said that he was crazy, that he had hallucinated, he was old and senile, he would run around and wander in the street; but a psychiartic examination proved to the contrary.

Senator PRYOR. Is it true that embalming fluid was actually mixed in with his food?

Mrs. ROBERTS. No, he threatened that he would actually poison him and he would put embalming fluid in his food. Consequently, Mr. Jones did not eat. His cousin was very nice; she was 80-some years old herself and is an invalid and offered to let him come into her home.

We petitioned the court for a conservator and now Mr. Jones does have a conservator. The court ordered Mr. Jones' son out of the home, ordered him to turn over his passbook. At this point, Mr. Jones' problems have been solved, but Mr. Jones is not the only one.

I have worked with the Protective Service for 10 years. I have worked in a nursing home and I worked there 7 years, and I have seen so much abuse to our elderly it is just pathetic. You would not believe some of the things, some of the horror stories. One of the Senators is gone now who reported about someone being sexually abused. I had a case where a lady—a mother-in-law as a matter of fact, 80-some years old, paralyzed—who was sexually abused by her son-in-law for 6 years. It took me a year and a half to get her to admit that to me. He also hit her on the head with a hammer when she would not give him her money or would not want to have sex with him.

This lady would not leave the home; she had not been outside in years, and she was fearful of leaving the home. Finally, when I just insisted—the law said you cannot force anybody to go anywhere—but this was one time that I insisted and made other arrangements, and I moved her into another lady's home, and that is where she died.

Then, the other day, I went out on a case where there was an elderly man who was lying on a mattress with the springs coming through the mattress. His apartment was infested with roaches, so many roaches it looked just like a beehive with the bees on it, and they were just crawling all over him and he was laying in his own waste matter.

This kind of thing, I just cannot see why the community would let human beings live this way, neglect our elderly. It just makes me sick to see things like this and I wonder how I can go on with the cases.

When I was a worker at D.C. Village, I saw abuse, I got sick to my stomach because of some of the abuse by some of the employees there. I went to the department heads and told them knowing full well I may lose my job. They asked me, "Are you willing to say this in front of the hierarchy?" I said, "Yes, I am." Then they said, "Well, we will call you." I was never called. Consequently I left D.C. Village. I applied for another job and left.

Then I went to D.C. General and then I came to Protective Services, where I have been working for the past 10 years, because I like elderly people; I always have. Last year, when Congressman Pepper had his hearings, I did make a statement that I thought there should be a protective service law, there should be a mandatory reporting of anything that you see—without reprisals. I would like to say to you gentlemen today that the faster you can get a law to protect the elderly the better, because I have seen 18 years of abuse and it is on record in my office. Every case that comes into our office is abuse, neglect, exploitation, or all three, and it is not isolated to the poor. It is the rich, the affluent and the poor, the rich and the middle income. It is all the way across-the-board and we cannot get any help.

I would like to say one thing about the police department. A lot of people said the police department would not respond to a lot of these things, but they do. I cannot say enough for the District of Columbia policemen. Whenever we call them, they are always there, and they know there is the law, the Irving law, that states, "Unless a person is harmful to himself or others," they can't do anything, and if they don't see them acting out, they can't do anything; but because of my persuasion—and I am very persuasive—they take them out of there, believe me. So I am hoping that there will be a law passed to make it mandatory that anyone, all the way across the Nation, anyone that sees an abuse or suspects an abuse, will have to report it.

Thank you very much.

Representative Pepper. Thank you very much, Mrs. Roberts. That is a very fine statement.

Mrs. Standley, would you like to speak next or would you like Mrs. Z to speak?

STATEMENT OF MRS. Z., OF CALIFORNIA, ACCOMPANIED BY MARCIA K. STANDLEY, SAN JOSE, CALIF., ADULT PROTECTIVE SERVICES, DEPARTMENT OF SOCIAL SERVICES, COUNTY OF SANTA CLARA, CALIF.

Mrs. Standley. I would like to make an opening statement for two reasons.

Representative Pepper. Are you with the Protective Services?

Mrs. Standley. Yes; I am with the Adult Protective Services. A great deal of what has happened to Mrs. Z occurred outside her immediate perception, and also it occurred during a period of 6 months when she was in a coma and awoke to find herself a pauper.

So my statement is as follows: Mrs. Z is now 92. At the age of 86, she was living with her sister in their own home, a home they owned and shared. Mrs. Z had a stroke and was hospitalized. She was comatose for 6 months. When she awoke from the coma she was in a nursing home and she was very fortunate in that she fully recovered with all her mental and physical faculties.

A few months before she recovered, her sister was placed in another nursing home by their former paid caretaker, who we will call Sue. At this point, Sue was representing herself as the probate conservator of the two sisters. To verify this, she had filed copies of conservatorship petitions in both sisters' medical records. It was later discovered that both petitions were withdrawn from the court calendar before they were recorded and there was no conservatorship. The papers looked official to the legally unaware.

This whole situation represents a degree of sophistication, which suggested to us that this is not the first time this individual has perpetrated this kind of an exploitation on an elderly person. She also had secured title to the sisters' home via a quit-claim deed signed by both sisters. Sue also later revealed that she had in her possession wills signed by both sisters which named her as heir in case either sister predeceased the other. Both wills named Sue as executor. Sue had powers of attorney signed by each sister.

All of Mrs. Z's signatures on the documents in Sue's possession are dated within the period that Mrs. Z was comatose. Sue successfully applied for medicaid for both sisters, presenting herself once again as conservator, with the same copies of petitions and claiming that she had given both sisters life estate in the house and had made them income beneficiaries by virtue of the trust she had set up. The trust turned out to be empty.

Mrs. Z, with her memory intact, began to ask questions about her affairs, her clothing, personal papers, family pictures, jewelry, her home, and her possessions. She was told that Sue is now in charge and has full legal authority. Mrs. Z questioned Sue and she got evasive answers. She noticed Sue was wearing some of her jewelry. Mrs. Z became angry and suspicious of Sue and protested, but no one would listen to her. The other sister, Miss D, now in another nursing home, expressed similar anger toward Sue. Sue had advised the nursing homes that Miss D was to have no contact with Mrs. Z and that even Mrs. Z's name was not to be mentioned because of friction between the two sisters. Miss D lapsed into total mental confusion and subsequently died about 3 years after placement in the nursing home.

I would like to point out that when something like this happens to a person, it frequently represents an enormous assault on their self-esteem. "What did I do to deserve this?" Frequently, the result is depression, withdrawal, and the failure to more aggressively pursue getting help. Frequently, this is because of the total loss of confidence and disbelief in one's own self-worth.

Representative **Pepper**. This Sue that you described, she was no relative of the family? She just volunteered to intrude herself into their affairs?

Mrs. **Standley**. The sisters had hired her daughter to drive them when they became visually impaired and unable to drive. When the daughter left, Sue moved in and was actually paid under the former old age security program to provide attendant services to these two ladies who were living independently but did require some supportive service in the home.

A few months before Miss D's death, Sue fell behind in the medicaid share of costs that were payable from Miss D's pension checks. It was at that point that the case was referred to the Adult Protective Services and a check was made of the court records to learn of Sue's management of the sisters' estate. At this time the conservatorship was found to be nonexistent.

About 3 years had gone by since Sue took over. Mrs. Z was informed that Sue's control of her affairs had no legal basis. Mrs. Z was questioned about what she had done and what she had written. She denied ever having made a will, signing over her house, or signing a power of attorney. She had no recollection, yet she could remember everything else except the time she was in the coma. Not only was she aware of not having signed the documents, she has remained steadfast in the fact that she had never intended to give her possessions to Sue, and does not think her sister did either.

The public guardian is now correctly appointed as the probate conservator of Mrs. Z and was Miss D's conservator until her death. The guardian retained an attorney and the groundwork was laid for suit, and a series of necessary, time-consuming legal procedures occurred. Sue hired an attorney, too. Mrs. Z has finally, after almost 6 years, recovered partial possession of her home and a few of her personal possessions. She is now 92 years old.

Representative **Pepper**. Would Mrs. Z now like to make a statement?

Mrs. **Standley**. Mrs. Z has requested that she be asked questions. It would be easier for her to respond to the points of interest on the part of the committee members.

Representative **Pepper**. Very good.

We will ask Dr. Steinmetz, would you like to speak?

STATEMENT OF SUZANNE K. STEINMETZ, PH. D., NEWARK, DEL., DIRECTOR, RESOURCES FOR OLDER AMERICANS, DEPARTMENT OF INDIVIDUAL AND FAMILY STUDIES, UNIVERSITY OF DELAWARE

Ms. **Steinmetz**. I am indeed pleased to have the opportunity to share with you my research findings and my concerns. Before relating some of them I do want to clear up a misunderstanding that we had to face with both child abuse and wife beating.

It was stated earlier that the family indeed provides very good care to the elderly person, and this is true in most cases, and that those individuals who abuse are psychopathologically ill, mentally ill. May I refresh your memories that this is exactly what we said about parents who abused their children, they were pathologically ill, yet subsequent studies show that while some of them were, most of them were as normal as you and I. We then were told the same thing about the men who beat up their wives. Again, the studies show that, like with child abuse, it is a series of circumstances such as frustration, inability to cope, lack of money, and so forth, that lead to the abuse.

I think it is important that we not label people who abuse other people as pathologically ill. We live in a society where the use of violence is perfectly acceptable in a large number of cases. We grow up being socialized to use violence when we are big, when we are right, when we are older, and when we have the law on our side. I think this acceptance of violence to resolve problems is, in part, the reason why we see so much abuse being used to resolve a problem.

Another point I would like to clear up is the comment, "There is not that much abuse to elderly by their children." Well, how much is that amount? Can you imagine the headlines tomorrow if it were announced that only 7 percent of the people in this hearing slapped, hit, killed, screamed, or threw something at each other? I mean surely that would be astonishing. Or better yet, if it came out in the newspaper that in your latest meeting at church last Saturday or Sunday or whatever night, that only 4 percent of the church members hit each other. You would think that was outrageous, and yet when it happens in the family setting it is not looked at as bad.

You get, well, 93 percent of the people are providing warm and loving care. That is true, but we need to be concerned about the 7 percent who are not. We need to be concerned about the tipping point, the families that reach a point at which they no longer can cope.

Now the families I am going to tell you about are from a research study that I am currently conducting. About one-third of the study has been completed, thus the findings are tentative, but I think they provide a profile of the problem. I also want to tell you why I have titled my testimony "Elder Abuse: The Society's Double Dilemma." We have a series of double dilemmas.

First of all, the elderly are doubly victimized. We saw this quite clearly with Mrs. X. You don't want to admit that you are victimized, you are afraid of what will happen. Even now she does not want her identity revealed. You are embarrassed that you have raised a child who would treat you this way, so you are caught. You are victimized if you stay in the home, you are victimized if you attempt to resolve it and find some other solution, because the fear of the unknown is often worse.

Women find themselves in double jeopardy. We know that women most often, compared with men, die in an institution instead of with family members. When men outlive their wives, they tend to marry younger women and so they have someone to care for them and they tend to die in the home. So what we find is that we have women taking care of women. Our study shows that the majority of the dependent elderly was just over 80. The average age of the care giver was 48.

That is a little misleading because we had a couple cases of what I would call a missing generation where you had a grandchild age 39 caring for a 99-year-old grandparent. In reality nearly 60 percent of those individuals who were caring for an older person would by definition be old themselves so we have a double jeopardy there. It is elderly people caring for still elderly people. You know the problems that all elderly people are facing, imagine the frustration put upon them when they find they are also responsible for a frail elderly parent.

We also have a double direction of violence and this has not been addressed today. Because of a lot of age-related diseases—stroke, late onset diabetes, and certain medications—there are often drastic personality changes that occur with some older people. We found in our studies individuals who were described as sweet, loving people all of a sudden becoming violent, difficult to live with, picking up things and smashing things, picking up things and smashing people.

The violence goes both ways. The elderly in most cases, the frail elderly, are not at fault, it is a medically related problem and it suggests we need much more medical research on how to cope with this. But it does go both ways. Even the best intentioned care giver, the kindest, most loving child who is in this parent role, will experience a tipping point, beyond their ability to cope, unless we provide adequate resources.

We had a number of families that when we asked them what was the tipping point at which they put an elderly person into a nursing home. We heard answers like: "The time when I no longer could control myself and I found that I was grabbing them by the shoulder and shaking them because I could not get something through to them." These children realized that they were out of control and it was a situation that they could no longer cope with.

This is also the caught generation, the double demands. The caregivers are very often caught in the middle. They have an older parent to care for and they have their own children and grandchildren to care for. They very often have a sick husband to care for because the caregivers most always are women. Were do your priorities go? Where does your money go? Where does your time go? One thing we found is that this is a long-term relationship. We have had individuals who were caring for a dependent elderly parent for 31 years. So we are not talking about a couple of years, we are talking about a solution that needs a large scale response.

Senator Pryor. Dr. Steinmetz, would you suspend momentarily. The other members of the panel, or the committee, may have questions for you, but I do feel that some of the witnesses that we have may be coming a little tired. If we could, let us proceed with a few questions for our panel and maybe even yourself.

Without objection, your prepared statement will be inserted into the record at this point.

[The prepared statement of Dr. Steinmetz follows:]

Prepared Statement of Suzanne K. Steinmetz

This last quarter of the 19th century can best be described by its shifting age structure. Not only will one out of every five persons be 65 or older by the close of this century, but the greatest increase will be among the very oldest citizens.

Between 1960 and 1970, those citizens 75 years and older increased at three times the rate of those in the 65–75 age group. Between 1970–76 the population between 40–64 increased just under 2 percent; however, those 85 and over increased by nearly 40 percent (U.S. Bureau of Census, 1977).

During the last quarter of this century, people under 65 will increase by 21 percent, those between 65 and 75 by 23 percent, and those 75 and older by 60 percent. These people over 75 are the most vulnerable to physical, mental, and financial crises requiring the care of their family and society (Brody, 1978).

This is the century not only of old age, but of multigenerational families, often several generations of near elderly, elderly, and trail elderly women. About one-half of all persons over 65 who have living children are members of a four-generation family (Butler, 1980).

There are other factors to be considered. The birth rate is declining, and while women are marrying at a younger age, they are having fewer children, and often putting off childbirth until later in life. This means there will be fewer members of the younger generation (Brody, 1978; Treas, 1977). Declining fertility restricts the older generation's access to younger kin to count on for assistance (Treas, 1977). In addition to the declining fertility rates, earlier marriages restrict and narrow the average span of years between generations. Several studies indicate the increasing phenomenon of multiple generations (Brody, 1974; Butler and Lewis, 1977; Neugarten, 1975; Townsend, 1968). Thus, we find families in which there are several members still living onto advanced age, while there are relatively fewer members of the child-parent generation available to provide assistance. Even today, it is not at all uncommon for one or two brothers or sisters to bear the responsibility for four or five individuals over 75 who are no longer able to live independently. Thus, we raise the question of who takes care of the caretakers when the caretakers need taking care of? Whose responsibility is it?

As the population of those over 65 grows in both number and proportion to the total population, they become a group identified as being unique and having special concerns. While extending the life expectancy has been a focus of biomedical research, the issue of quality of life has minimally been addressed.

Another gap in research has been the inattention of quality of life issues in the noninstitutional private sector. For example, State and Federal hearings on victimization of the elderly, both in nursing homes and on the streets, have been held, however, only 5 percent of the elderly reside in institutions, and recent data suggests that while elderly exhibit greater fear, they suffer proportionately fewer crimes (National Crime Panel Survey Report, 1976). Possibly one of the single greatest sources of abuse and neglect of the elderly is perpetrated by family members especially in generationally inverse families (families in which the child has assumed a caretaking role; the parent is now in the dependent role). Yet, assault and battery of the elderly, is no less a crime if it happens at the hands of family members.

The title of this testimony, "Elder Abuse: Society's Double Dilemmas," was chosen with great care. There are several doubles to be explored. First, like other aspects of family violence these victims are doubly victimized since they are not only dependent on the abusers for basic survival needs, but bear the stigma and guilt of having raised a child who would mistreat them (as well as fear of the unknown) if they seek help to alleviate the violence.

Second, the overwhelming majority of caregivers are women and likewise they comprise the overwhelming majority of vulnerable elderly. Women, then face double jeopardy; they bear the stresses and strains of caring for an elderly woman and they face a high probability of being in a similar situation (Brody, 1979; Black, 1979; O'Malley, 1980; Steinmetz, 1980a). A 68-year-old caregiver blames her divorce on having to care for her demanding, selfish 82-year-old mother. She notes "That was one of the contributing factors, my husband just had it up to here. One day he just left." This caregiver later notes that her mother won't offer to contribute to household costs "I'm making a woman's salary and keeping a big house . . . . It's an obligation which I think she should partly assume." She doesn't feel that way. "I'm her daughter, she gave me life, she provided for me when I was young and couldn't do for myself, this obligation is not on my shoulders."

A third dilemma is the double trouble faced by caregivers—elderly themselves, by standard definitions (60 or over) caring for still older dependent kin (Foulke, 1980; O'Malley, 1979, Steinmetz, 1980b).

The fourth dilemma is the double direction violence. While violence perpetrated on the elders by their adult children has been sensationalized in the media, violence by elders on the middle-aged or older children has remained hidden (Steinmetz, 1980b). The authoritarian father who ruled his children with an iron fist and met a loss of authority or control with a beating apparently still resorts to these techniques at age 90, and finding control over the "children" more difficult, resorts to temper tantrums and physically violent outbursts.

The final dilemma is that of double demands. The caregivers often find themselves caught between two or more generations. At the very time that one's own family income is leveling off, retirement plans imminent and college and wedding plans of one's children a costly expense, this middle generation often has to assume the costs of caring for their parents (Cohen and Gans, 1978; Silverstone and Hyman 1976). The value system also is strained—where does one put their priorities: the parents who reared them or their children who they still have responsibility towards. Caught in this dilemma the middle generation often find that there is no physical, psychic or financial cushion for themselves.

Society's double dilemma is of major importance because it is a dilemma which most of us will face: first, as a caregiver and later as we grow older and become dependent. Therefore, it is critical to bring national attention to this problem; which will motivate experts and interested professionals to gather data and exchange knowledge; and stimulate future research, education, and policymaking on the State and Federal level.

The area of domestic violence (spouse and child abuse) has been explored in depth and has become the focus of several congressional hearings and received national attention. Abuse of the elderly within the family setting however, has been limited to a U.S. House of Representatives Select Committee on Aging briefing, a few academic articles, and an occasional exposure by the mass media (Quincy, Prime Time, Walter Cronkite). Although State and Federal hearings have been held to examine nursing home abuses, this hearing represents the first congressional hearing to address abuse of the elderly within the family setting.

Research has shown that the most frequent abusers of the elderly are family members (Block, 1979; Douglass, 1979; Steinmetz, 1978). Steinmetz (1978) has estimated that almost 10 percent of the dependent elderly are at risk. Thirteen percent of service providers who responded to a mail survey (Block, 1979) reported abuse; however, eighty-eight percent were aware of the problem of elder abuse, even if they had no cases to report. Seventeen percent of a mail survey of professionals in another study reported physical abuse of an elder, and forty-four percent reported verbal/emotional abuse (Douglass, Hickey and Noel, 1980).

In a single year, 1978, Baltimore city police department reported 149 assaults against individuals 60 years or older. Nearly two-thirds of these assaults (62.7 percent) were committed by relatives other than spouses (Block, 1980). During the first eight months after passage of the elderly protective service law there were 87 cases of physical abuse, 314 cases of neglect, 65 cases of exploitation and 8 cases of abandonment (Block, 1980).

After completing about one-third of the 30 interviews with adult children who were caring for a dependent elderly parent (Steinmetz, 1980b), the following profile emerges. The average age of the dependent elderly was just over 80 and their ages ranged from 60–99 years. The average age of caregiving "children" was 48 with a range of 23–65 years. The average age of caregivers was somewhat lowered by several instances of a missing generation, adult children caring for grandparents such as a 23-year-old caring for a 79-year-old, or a 39-year-old caring for a 99-year-old. Thirty-nine percent of the caregivers were over 50 years of age and 18 percent were 60 or over. Thus, 57 percent of the caregivers were elderly or rapidly approaching this stage themselves. Most respondents were women and their husbands tended to be still 2–3 years older.

The effects of this additional burden on "older" caregivers is suggested by the comments made by one 60 year-old respondent regarding her 84 year-old mother.

"I don't consider my mother a burden: I would be glad to continue to care for her if she was not unpredictable and I could. This is the selfish part. I want to do some of the things I like to do because I'm not very young either. . . ."

You have the elderly children taking care of the elderly. As a result of conflicting demands abusive and neglectful methods of control become methods of last resort. A preliminary analysis of the study provided the following negative methods of control:

TABLE I.—*Methods used by adult children to control their elderly parents*

Behavior:	*Percent*
Screamed and yelled	40
Used physical restraint	6
Forced feeding	6
Threatened to send to nursing home	6
Threatened with physical force	4
Hit or slapped	3

As noted earlier, the violence is double direction and the elderly also use violence as a control mechanism. We know that violence is often the methods of last resort used when it is observed (or perceived) that no other methods will work. The relatively lower physical, financial, and emotional resources of the elderly parent may account for the high levels of violence observed. However, age-related diseases and medications which alter personality must also be considered.

The elderly use a range of techniques as controlling mechanisms. However, guilt producing ones appear to be the most common (see table II).

TABLE II.—*Methods used by elderly to control their adult children*

Behavior:	*Percent*
Scream and yell	43
Pout/withdraw	47
Refuse food/medication	16
Manipulate/cry/use physical or emotional disability	32
Hit, slap, throw	22
Call police or others for imagined threats	10

Some parents apparently never understand that their children are adults, since 63 percent of the caregivers reported that their elderly parents didn't respect their privacy.

Other elderly parents still attempt to rule with an iron fist much in the way they did when their children were young. One woman in her late 60's was unable to leave the home to be interviewed because her 94-year-old father felt it was her place to remain at home to answer his demands. When she would leave he would violently attack any caretaker left with him and turn the room into shambles.

Another caregiver mentions that her mother was raised to "honor thy father and mother." Parents are right and always are, up until the hour of death. You don't talk back. One day she told me I talked back to her. Here I am a great-grandmother, talking back.

The problems created by increased longevity are not confined to the elderly but encompass the whole family life cycle. The middle-aged child is often unable to cope with problems arising within their own nuclear family (Silverstone and Hyman, 1976; Kirschner, 1979). This additional burden of shouldering the parent's problems becomes a tipping point with a potential for abuse and neglect (Rathbone-McCuan, 1978; Steinmetz, 1978; Steinmetz, 1980b). The change from being cared for to caregiver may build feelings of resentment and misapprehension in both generations (Hooker, 1976; Knopf, 1975; Silverstone and Hyman, 1976). Feelings of love and respect can easily be turned into guilt, hatred, and disappointment by the children in their attempt to deal with the new role of caregiver (Cohen and Gans, 1978; Knopf, 1975). Unresolved conflicts between parent and adolescent age children often continues throughout the life cycle (Bozzormeni-Nagy and Spark, 1973; Brody, 1966), resulting in contact remaining at the level of obligatory vacation or holiday visits during the "child's" adulthood. In view of these still unresolved conflicts (Cohen and Gans, 1978; Silverstone and Hyman, 1976), it is unlikely, that the child would shoulder the responsibility of caring for an elderly parent with open arms and a warm heart.

Thus, the motivation to care for the kin may not only be out of love and concern, but often out of a sense of responsibility, duty, or guilt (Brody, 1970; Otten and Shelly, 1977; Silverstone and Hyman, 1976).

When this child generation is responsible for two or more older kin, the pressures and strains which vary with the degree of dependency needs of the elderly person, can be severe. This problem is further intensified because as our data has shown, the caregivers themselves are often elderly. Thus, this elderly caregiver, in addition to preparing for retirement, fixed income, and increased health problems bears the major responsibility for a still older parent or kin.

As economic, physical, social, and emotional dependency needs of the vulnerable elderly increase, the potential for abuse, unless adequate resources are available, likewise increases (Blenker, 1965; 1969). Economic dependency, with the loss of economic power, produces loss of control, self-esteem, and prestige for the elderly person as well as producing an economic drain and conflict over competing goals for utilization of limited resources within the caretaking family (Steinmetz, 1980a).

Another form of dependency, physical dependency, also becomes a problem for the caretaker (Knopf, 1975). Physical deterioration may be evident by loss of hearing, decreasing sight, or strength (Hooker, 1976; Knopf, 1975). Severe or chronic illness which often accompanies aging places additional burdens on the caretaking family. Medical costs are frequently not compensated or at best undercompensated by Federal and private health insurance, and compete with other expenses incurred by the care providing family such as their children's education, weddings, as well as plans for their own retirement years.

Social, psychological, and emotional dependencies must also be dealt with. Foulke (1980) found that physical dependencies were easier for caregivers to deal with and produced less stress than did social/emotional dependencies. Most often it was the decisionmaking associated with emotional dependency that was stressful for caregivers (Foulke, 1980).

The restricted availability of personal time also becomes a source of conflict. Many respondents in the study resented not being able to go out with one's spouse or visit friends or family without taking the elderly parent along. Thus not only is additional time required to care for this dependent elderly, but any free time spent to fulfill the caregivers personal needs is often viewed by the elderly kin as an indication that the family is rejecting him/her.

Control over one's environment and lack of privacy pose additional struggles for both generations. In order to have a smooth running home, one assumes that all members must function interdependently, and yet it is very often difficult for the older person who has been transplanted from his/her home to find an appropriate role within the new setting. Since this problem is predominately faced by women (Brody, 1970; Hess, 1979; Morgan, 1969), it takes on an additional dimension: the rivalry between mother and daughter over the appropriate ways to manage husband, household and children (Farrar, 1955; Johnson, 1978).

The problem of elder abuse is complex. Information on this aspect of family violence while increasing is still limited. Until recently, the general public associated this problem with maltreatment of persons in poorly run nursing homes and dilapidated boarding houses. While parallels have been drawn between child abuse, wife abuse, and elder abuse (Steinmets, 1978), little has been done to either understand elder abuse or focus its unique properties.

There are a variety of patterns that create the setting for abuse (Renvoize, 1978). Burston (1978) has suggested that a hastily made decision to have an aging parent come to live with an adult child may create conditions for eventual abuse. Because the decision was reached at a time when family emotions run high, family members may feel they were forced into taking in the aging parent (Douglas, 1979). Power conflicts (Renvoize, 1978), increased disability (Lau and Kosberg, 1978) and dependency of the older person and the existence of a high level of family stress (Steinmets, 1978); produce the potential for violence. Individual perceptions, attitudes and stereotypes can also serve as catalysts for elderly abuse.

Difficulty in obtaining services or lack of services further hinders healthy resolution of intergenerational problems. One respondent related the problems encountered in getting help for her 89-year-old father.

"We couldn't get help from medicare, medicaid, Blue Cross. Everything fell onto us financially . . . because he required custodial care. I think I called about 30 people in the State of Delaware trying to get information. It was very frustrating . . . social security was over the cutoff amount. He didn't have a suitable income as far as pension . . . Here was a man who did for others all his life and when it came his turn to try to get some help, there was none."

Financial eligibility for services when they are available provides another obstacle. In order to be eligible for benefits, it is often necessary to spend down all the family's assets resulting in what Butler calls the creation of pauperized widows. This frustration was exhibited by one respondent attempting to get help for her 87-year-old mother:

"I went to social security to put her on medicaid. They said how much social security does she get? I told them $160. They told me you know you mother has to pay her fair share . . . They said you have to add up all your expenses. If your expenses are $1,200 a month and there are four people living in the house . . . you divide four into $1,200, that is $300 a month in order for her to be eligible for medicaid. I made them explain it and go over it four or five times. I said, 'Look, my mother doesn't have $300 a month. Where is she going to get the other $140 a month to pay her fair share?' I did a work up of my bills, electric, heat, all the necessary items. They determined that she was not eligible and told me that she could get food stamps. What good does that do? None. Not for the medical problems we were facing . . . She had Blue Cross/Blue Shield but in order for them to pick up that tab, she had to go directly from the hospital into a nursing home. Nobody would take her into a hospital. The one time she was in there right before she died, they sent her home . . . There was no legislative help. No one could cover the cost of in-home help . . . It's a horror story I'll tell you."

The stories are vivid—abuse and neglect of elderly being cared for by family members, often themselves elderly. It is critical that Congress respond. Legislation is needed to protect the vulnerable elderly. Social services are needed to support families caring for an elderly parent. It is a disgrace that a neighbor can receive financial compensation for caring for an elderly person, but the children of this elderly individual are not eligible for financial help. Education is critical. We need to have a better understanding of the aging process and the responsibilities incurred when you assume the role of caring for a dependent elderly parent.

Studies of family violence clearly indicate that violence is a learned behavior transmitted from generation to generation. The national study of domestic violence (Straus, Gelles, Steinmetz, 1980), found that when children are treated nonviolently the probability of them attacking a parent is about 1 out of 400. If the child is treated violently by the parent, the probability of them attacking their parent is 200 out of 400. This provides strong support for the need to emphasize nonviolent methods of family interaction if we want to break the cycle of violence.

DEFINITIONS

Abuse: "The willful infliction of physical pain, injury or mental anguish, unreasonable confinement or willful deprivation by a caretaker or services which are necessary to maintain mental and physical health."

Neglect: "Caregivers inability or unwillingness to provide services which are necessary to maintain an elderly persons mental and physical health."

Abandonment: "The desertion or willful forsaking of an elderly person by a caretaker or the foregoing of duties or the withdrawal or neglect of duties and obligations owed an elderly person by a caretaker or other person."

Caretaker: "A person who has the responsibility for the care of an elderly person as a result of family relationship or who has assumed the responsibility for the care of the elderly voluntarily, by contract or by order of a court of competent jurisdiction."

Dependency: "As the elder passed from the independence through the stages of interdependence into full dependence, a hierarchy of tasks performed by the adult child can be identified (Foulke, 1980). Six different dependency categories can be defined: Household, personal/health care, financial, emotional/social, mobility and mental dependency. Each succeeding stage encompasses not only the tasks of the preceeding stages but a new set of additional tasks (see figure 1).

Elder: "Any person 60 years of age or older and residing in a noninstitutional setting, including persons living alone, with family or friends or with a caretaker."

Battered aged: "Elderly parents who reside with, are dependent on and battered by their adult, caretaking children."

Violence: "The intentional use of physical force on another person, or noxious physical stimuli invoked by one person on another. The physical force may be viewed as assaultive, designed to cause pain or injury as an end in itself, sometimes referred to as 'expressive violence,' or as the use of pain or injury or physical restraint as a coercive threat or punishment to induce another person or persons to carry out some act, commonly called 'instrumental violence.' Violence may also be legitimate . . . or illegitimate . . . but behind illegitimate violence are cultural dimensions that involve the acceptance of violence."

Family: "As used in census reporting, refers to a group of two or more persons related by blood, marriage, or adoption and residing together."

Multigenerational residence: "The interaction, communications and living arrangements of individuals related by blood, marriage, or adoption. The critical dimension in defining a circumstance remains with the individuals. The setting may be a room in the adult child home, an "apartment" in a former family room, half of a duplex or a trailer in the backyard. The important variable is the family's perception of sharing a common residence."

Generational inversion: "The subtle role changes in supportive interaction between the parental generation and their adult children which takes place at the latter portion of the life cycle. This relationship is characterized by the elder experiencing one or more dependencies and the adoption of "parent-like" behavior by the adult child."

STAGE I →	STAGE II →	STAGE III →	STAGE IV
Independence Dependence	Reciprocal Dependence	Asymmetrical Dependence	Survival Dependence
Tasks Performed by Caregiver	Tasks in Stage I plus -	Tasks in Stages I and II plus -	Tasks in Stages I, II, III plus -
- grocery shopping	- writing checks	- understanding doctor's orders	- helps make calls
- transportation	- paying bills	- dispensing medication	- needs protection-elder cannot be left alone
- runs errands	- managing resources	- washing, setting, cutting hair	
- laundry	- provides social life for elder	- helping with decision making	
- provides emotional support to elder		- assisting with walking when elder is outdoors	
		- help elder get in and out of car	
		- encourages elder to develop new interests and friends by arranging social contact	

Figure 1 Stages of Elder's Dependency with Tasks Required to be Performed by Caregiver (Foulke, 1980)

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Senator PRYOR. First, I would like to ask the question, if I might, to Mrs. Z from California. Mrs. Standley, you may assist her in this answer. I would like to know from Mrs. Z if she hesitated to report the abuses that had been inflicted upon her. Was there hesitation about bringing this matter to someone's attention?

Mrs. STANDLEY. What Mrs. Z had told me is that she never imagined what the full extent of the exploitation was until we told her what we had discovered in the records. She could not believe that the title to her house had passed from her. She did protest the loss of her pictures, her personal papers, her jewelry. She asked about her furniture and her clothing and got no answers. Since she was alleged to be conserved, it was my impression that those people who were caring for her in the nursing home wrote her off as a slightly paranoid and confused old lady who was fortunate enough to have a lovely person caring for her. My experience with exploiters is that they are all terribly nice people that are just trying to help. It is white-collar crime.

Senator **Pryor**. At that time, was she being administered drugs? Was she being given drugs at this particular time?

Mrs. **Standley**. No, she was not. She was fortunate in that she had a very wonderful doctor who kept her spirits up and who related to her anger and her distress and really didn't know what he could do for her besides give her the best medical care possible.

Senator **Pryor**. The protective service agencies are not unaware, though, that it is common for the elderly to be drugged, basically not only by physicians, but also by hospitals and nursing homes, to keep them in a certain state; is that correct?

Mrs. **Standley**. Yes, that is certainly my experience. Many well meaning doctors give PRN—as needed—orders for medication to nursing homes which the nursing homes interpret as to be given any time they need to keep the patient quiet. So the order might be interpreted as twice daily, or every 24 hours, or any time.

Senator **Pryor**. I will pass on to you now, Mr. Chairman.

Representative **Pepper**. Thank you.

Let me start with Mrs. X's case. The net result of it was, as I understood Mrs. X's statement, that she eventually found a happy residence in a nursing home but she had to give up her own home. Instead of the daughter getting out of the house, apparently the mother had to give up her home to have any measure of peace. Is that true?

Mrs. X. My daughter is in the home now, but I am going to sell the home. I will be allowed to sell the home and she will have to find another place to live.

Representative **Pepper**. What I observed from the excellent and moving statements that have been made here today is that it is essential that there be agencies such as the protective agencies who have testified here today to help these people who are flexible enough in their work to be able to do whatever is necessary to help the individual. That is not enough to assume the individual will get access to the courts and the courts will protect the individual. Somebody has to help get the reversal that the courts are able to give. Do you agree with that, Ms. Collins?

Ms. **Collins**. Yes.

Representative **Pepper**. And you, Mr. Bergman?

Mr. **Bergman**. Yes; I do.

Ms. **Collins**. I would like to mention that Mrs. X is not in a nursing home, she is living in an apartment with a friend.

Representative **Pepper**. I see.

Did you agree also, Dr. Steinmetz, that it is essential to have these administrative agencies that can go into the home and see what the condition of the elderly person is and render such help as is necessary with that individual?

Ms. **Steinmetz**. I agree and I think you need to have the money to back up the adequate services. All too often we have the law to go in and discover that the problem exists, but there is not adequate money to allow the services to remedy it.

Representative **Pepper**. Mrs. Roberts, is that your opinion, too?

Mrs. Roberts. That is exactly what our office does. We do go in and when we find a problem we set our goals and what we want to do, along with the clients, if they are able to. The only thing, one of the problems is money. They have cut back homemaker service. There is no more homemaker service in the Department of Human Services now for the elderly homemaker charge. Intake is closed. There is no more chore services. When their check goes up, they cut off the medicaid. They get maybe a few dollars over the amount. We just do not have the services. We go out and we use the community and private agencies like Family and Child Services, but we just don't have the money.

Representative **Pepper.** Well, I am going to invite your other comment. It also seems to me to be necessary due to the reluctance of elderly people to report these abuses as, for example, in the case of Mrs. Z. They let this strange woman, who was obviously exploiting them, to get their money and their property, come in and take away a lot of their goods and upset their lives and everything, and a long time elapsed before they even did anything about it. They didn't even know what to do or were reluctant to do it. Apparently somebody found out about this. How did you find out about it?

Mrs. Standley. The nursing home was not getting paid the share of cost, not because there was any question that something had been done that was inappropriate to either of the ladies. It was after I investigated as to how the alleged conservator was managing the estate that I found out about the fraud and the transfer of property and the total loss of everything owned and possessed by Mrs. Z and Miss D.

Representative **Pepper.** You mentioned also that one of the ladies was physically disabled part of this time, in no condition to report to the court. It seems to me that I am beginning to get the impression that if we are going to give adequate protection to the elderly in view of their illness at all times that prevented their reporting or their disinclination to report that we really need protective services to go to every elderly person and see if they are getting on all right. There may be any number of cases where they are not, but you don't know anything about it.

What do you think, Mr. Bergman?

Mr. Bergman. Mr. Chairman, I think you are absolutely correct in this. One of the major problems is gaining access to the home. Certainly, State legislation, such as Congressman Ratchford was able to get passed in Connecticut a number of years ago, can provide that initial access. But, once the access is gained a worker still may spend weeks, months, sometimes years, as has been pointed out, trying to get the victim to agree that something has happened to them, that they do need help, and that help can be gotten without fear of retaliation. That type of situation requires exactly what you are suggesting: Protective service workers who can go out and spend the time necessary to develop rapport with the victim and then be able to suggest that there are alternatives. Many times, the only legal remedies available are restraining orders or vacate orders. Suing to regain possessions is not normally the major thing that needs to be done. Oftentimes, it is counseling that is needed to enable the victim and the abuser to recognize what they are doing to each other and that there are ways of relieving that. Sometimes, getting the victim out of the home or into a senior center a few days a week to relieve some of the stress in the home to enable the family to work together again is the greatest need.

The last thing we want to see is families being unnecessarily taken apart because there are stresses or because one or another member of the family has severe psychological problems which could, in fact, be treated if the person were willing to admit the problem and were willing to swallow his or her pride and say, "I want to do something about it."

Representative **Pepper**. There is just one more question, and then I must pass on to my colleagues. How do you people in the protective services know who are the elderly people in your general area and where they live?

Mrs. **Standley**. We learn of them because we get referrals. The referrals come from community members. It is seldom that the elderly persons themselves call.

Representative **Pepper**. You mean some neighbor or somebody?

Mrs. **Standley**. It would be a neighbor or an attendant in a care facility. It can be a doctor, sometimes an attorney. It is hardly ever a real estate salesman. Sometimes it is another social worker or home health agency. The important thing is that the referral come in as early as possible before irreparable damage is done, before families are divided, before illness and death occurs. As far as trying to recover a person's property, as you can see, it takes years to go through the courts.

Representative **Pepper**. Census information is not accessible?

Mrs. **Standley**. No; that is not what is going to do it. Community education and the kind of sensitivity to the problem that this committee is attempting to do here is going to help with the referrals. If we evaluated every person over 65 for the possibility of a need for protection, it could come close to a violation of rights. Unless the community understands——

Representative **Pepper**. You could make a courteous call and just have a courteous conversation with them and see enough maybe to give you some indication as to whether it should be pursued further.

Mrs. **Standley**. That is very true.

Representative **Pepper**. I believe it would be very meritorious if more initiative could be exerted on your part to just sort of check up to see whether there were people being abused who were not able to report.

I want to announce Mr. Ratchford of Connecticut, whose good work is already noted, Mrs. Ferraro of New York, and Mr. Mica of Florida have come in. We are delighted that you have joined us. If you have any written statement for the record, it will be received or if you want to make a brief comment.

Mr. Ratchford.

STATEMENT BY REPRESENTATIVE WILLIAM R. RATCHFORD

Mr. **Ratchford**. Mr. Chairman, thank you for allowing me to make a brief comment.

Attorney Bergman made reference to the Connecticut experience. In Connecticut, we discovered elder abuse almost by accident. I chaired a nursing home investigation which looked at abuse in institutions. Out of that we developed a nursing home ombudsman law which mandates reporting. It is a series of voluntary patient advocates in the home and general ombudsmen who are State employees geared specifically to pursue complaints. We then discovered that probably there was even greater abuse in the community.

One particular case was responsible for the passage of Connecticut's elderly abuse statute. In Middletown, Conn., it was discovered that a grandmother living in a tobacco road situation had been chained to her bed for the better part of 2 years. That was the family's way of coping with senility. In addition to the chaining, she had been physically abused and there was evidence of bruises of long-standing on her body.

As a result of that, Connecticut passed an elderly abuse statute which mandates reporting, which allows the appointment of a conservator, which we did in this particular case, and which obviously allows for prosecution where it is necessary.

The one postscript or caveat I would make is the statement of one of the professionals, and that is, if you are not going to staff systematically, you hold out false hope to the community. So, to this panel I would say, if we consider national legislation, putting a law on the books in and of itself is meritorious, but it is not enough if we are not prepared to staff it.

Thank you.

Representative **Pepper**. I am informed that only 12 States have the protective services, so it seems to me further afield for us to see if we cannot set up Federal machinery that would encourage the other States to have them and assist them in the administration of their duties.

Mr. **Ratchford**. Briefly, it is indeed, Mr. Chairman. I would encourage you, if you take that route, to take advantage of the good services of Attorney Bergman because he has analyzed all the State statutes and is one of the experts as far as the statutory law in this area.

Representative **Pepper**. We will start with Mr. Grassley.

Excuse me just a minute, Mr. Grassley.

Mrs. Ferraro didn't make a statement. We would welcome your statement.

STATEMENT BY REPRESENTATIVE GERALDINE FERRARO

Representative **Ferraro**. Thank you, Mr. Chairman.

I appreciate the opportunity at this point to make a comment. My background is that, prior to my being elected to Congress, I was with the district attorney's office in the county. We handled child abuse, we handled all sexual abuse cases, and we also handled senior citizens' homes. We occasionally were called upon to prosecute crimes against the elderly with reference to abuse.

Unfortunately, what you are discussing today, there is a reluctance of the witness to come forward and express concern because of embarrassment as well as fear. We had very clear evidence and when the prosecution was started, it was almost never completed because of the failure of the witness to come forward to assist in the prosecution.

New York State is one State which does not have the mandatory reporting in instances of adult abuse. It does have it where child abuse is concerned.

We had hearings in New York, as you know, on this topic. Congressman Biaggi had these hearings and I participated. One of the problems that was indicated to us is that if we do have mandatory reporting, what we are doing is, we are extending and saying, you must report the crime, and we are not following up with the services. I think the problem of adult abuse comes down to five little letters—namely one word, which is money.

I am certainly appreciative of the fact that I am here to participate in this hearing, but I feel a great sense of frustration when you are dealing with this particular problem because if we have the people coming forward and we don't have the money to deal with the problems, it is a real concern.

I thank the witnesses.

Representative **Pepper**. Thank you, Mrs. Ferraro.

Mr. Mica.

STATEMENT BY REPRESENTATIVE DAN MICA

Representative **Mica**. Thank you, Mr. Chairman.

I just would like to say that, being from the State of Florida, the same State as our chairman, and that being the State with one of the fastest growing elderly populations in the United States, I am appalled at what I hear. I am pleased that Florida does have elderly abuse legislation on the books. These hearings, I hope, will spur all of us to bring this, as the lady indicated, to the public attention and try to get an educated public to bring these to the attention of those responsible for resolving the problems.

Thank you, Mr. Chairman.

Representative **Pepper**. Mr. Grassley, do you have any questions of the panel?

Representative **Grassley**. Yes. I would like to ask Ms. Collins, Mr. Bergman, Mrs. Roberts, and Mrs. Standley this question. It has already been stated that 15 States do have elder abuse laws. You have indicated in each one of your States that the State law is adequate. Do you feel that there is need for national legislation applicable to all States? Would Federal law add to the level of protection provided to the elderly by the laws of your individual States? Are there advantages to a Federal law? I would like to have all of you answer.

Mrs. **Roberts**. I think that there should be a law for all the States that it should be mandatory that everyone report any kind of abuse. Here in the District it is not mandatory. We do not have a law. I believe Councilman John Wilson introduced a bill for a protective law in 1978. He introduced a bill for protection of the elderly and also for conservatorship and it was tabled and never acted on. As usual, the elderly are always left until last.

Mr. **Bergman**. I don't want to leave the impression that Massachusetts has a good law. It does not have any type of mandatory reporting law. Secretary Mahoney, from the Department of Elderly Services in Massachusetts, will spend some time in the next panel on what we are trying to do in Massachusetts to gain passage of a mandatory reporting law. I think the State is building upon what I consider to be the best law right now, and that is the Connecticut statute. Certainly, Massachusetts right now is still not there by any means.

Ms. **Collins**. I just wanted to mention that there are known instances of elderly abuse where community people can do nothing about it, not even gain access to the house. In one case in a small town, an elderly woman who was a stroke victim and could not talk and was basically a bed patient was at home with her husband who was a retired policeman and an alcoholic; a violent alcoholic who everyone was afraid of. He would periodically bar the visiting nurses from coming into the home to care for her so that when they did get in they would find her covered with her own feces and totally unable to complain. Their children lived out of State and were terrified of their father and would not do anything about it.

So even though this was known to everyone in the area, nothing could be done about it. Thank God she was hospitalized. He wanted to take her home for Christmas and the social worker was very persuasive and was able to talk him out of that but she called me to see if there was anything we could do about it. I called Jim's office and was told absolutely not; there was just no means of dealing with that situation. I am sure that there are other similar situations like that that people know about and nothing can be done.

I think that the value of national legislation would be in setting funding priorities for the States and putting the money there, because it is money that we need. The only reason that Mrs. X had a protective service worker is because my agency started the program with title III Federal funding on its own initiative. It is not a Massachusetts program.

Representative **Grassley**. Mrs. Standley.

Mrs. **Standley**. The State of California does not have a mandatory reporting law, either. Legislation was introduced, I believe, last year, and it is bogged down in the legislative process someplace. The knowledge in the State and in the community of the extent of this problem just really is not there. Our department has had an adult protective services unit, a specialized unit, for over 10 years because of the perception on the part of the agencies and the professional caretakers in the community, but not because we were required to have a specialized unit.

I think that since the abused person so often is either unaware or ambivalent about reporting and really wants help for the abuser when it is a close family member as much as for themselves that having a mandatory law really is not going to accomplish a great deal unless the help is available, because a law that is only able to punish is simply not going to be utilized or accepted by those people who are abused.

Representative **Grassley**. You indicated in Mrs. Z's case that nobody was aware of the abuse, so in that particular case what good would the mandatory reporting law do?

Mrs. **Standley**. I would like to make some suggestions. When a person is placed in a care facility and somebody else is handling their money, the care facility should be knowledgeable enough to properly verify that person's right to act as a fiduciary and should have an obligation to clarify that person's right to handle the patient's money.

In the case of the application for medicaid, I must say that the people who handled the application were as ignorant as the nursing home and had no obligation to verify the conservatorship's either. There are, I think, some small, subtle ways besides just requiring reporting which would give the person the knowledge of what to report.

Representative **Grassley**. This will be my last question, Mr. Chairman.

Mrs. Standley, in response to the chairman's question about the potential of visiting every elderly person to assess whether or not there was elder abuse I believe you suggested that might be going a little too far in the sense that we might be infringing upon some people s rights and you would rather rely upon referral. Is that correct?

Mrs. **Standley**. Yes; I said that in response to the idea of having a protective services person screened to evaluate each elderly person. For instance, when elderly persons retire at age 65, they don't think of themselves as needing the kinds of services they may need 10 or 15 years hence; they don't think of themselves as being exploited or abused. If the awareness is there in that individual long before it can happen or it does happen, then they will be more sensitive and more able to accept the need to report themselves, especially if they know there is somebody to report it to.

By the same token, most seniors come in contact with senior services of one kind or another, supportive services of one kind or another, not necessarily protective services. If those service providers and provider agencies were sensitively aware of the protective services available and of the potential remedies for physical and financial abuse, they would make appropriate referrals in the context of the services that they were already providing and leave the protective services people to focus on the actual problems as they had been perceived rather than giving them with the responsibility for doing screening on the total elderly population.

Representative **Grassley**. Thank you, Mr. Chairman.

Representative **Pepper**. Miss Oakar, do you have any questions?

Representative **Oakar**. Thank you, Mr. Chairman.

First of all, Mr. Chairman, let me just thank the older people for coming forward and being so heroic. I personally am very, very grateful because you have been the victims and you are the primary sources in this instance, and also the agency people who have been so supportive to them.

I mentioned in my opening remarks that today I was introducing an Adult Abuse Prevention and Treatment Act and it is based on a couple of years of study. Frankly, we found that Connecticut's law was just about the best in the country at the State level, which is certainly a credit to my friend from Connecticut. I would like to extend the invitation to those of you who are testifying, along with those who are in the audience, to respond to the bill and make suggestions.

It does provide for immunity for those who are reporting; it does make it mandatory. It also provides for protective services and legal recourse for most States to conform. Experience has shown us with the Child Abuse Act that when the Federal Government provides an incentive for States to have programs they fall in line when they have some funding available, for example.

I would like to ask the people from Massachusetts, if I might, because you made such a point in your testimony, do you feel that you know most of the cases involved in adult abuse, or if you had a stronger law that would provide for mandatory reporting and immunity, would you indeed perhaps know about more cases? It would be difficult probably for you to handle all of them, I am sure, but I just wondered if you would comment on that because I am somewhat interested.

Mr. **Bergman**. There is no question that we have barely touched the surface of elder abuse cases. South Carolina's experience, and Connecticut's experience, have shown an immediate leap in the number of reports, once mandatory reporting laws have been passed and implemented. I think Connecticut in the first year that it was beginning to get its program underway, had approximately 1,100 cases of neglect, exploitation, abuse, or abandonment. In the second year, the numbers are going up higher. There is no question that more reports will come in. A key to that is public information. Immunity for reporters is important; in fact, it is critical. But, public information, just as in spouse abuse cases is the most critical factor because unless people know there is a remedy available, they do not act to protect themselves.

We had a recent experience in which a local TV station ran a program on elder abuse and gave our phone number. Within 5 days, we had 35 cases reported to us, including for the first time, a number of victims calling up, saying, "I am a victim; I need help." Usually the referrals, as I said, have been from someone other than the victims. So public information is key.

While I have not read your bill, I think all of us have suggested that the reporting laws probably should be State-based. But there is much that Congress can do. The national centers and regional centers which have been established to assist with child abuse cases could be replicated for elder abuse cases. Such elder abuse centers could be a major impetus in helping States share information, such as Connecticut's law; that is a good one.

Frequently, we don't pass information back and forth that well. Backup centers would be a major help. Providing cash incentives for States through the title XX social service program, could also serve as a major impetus. There could be 90-percent Federal reimbursement for programs of adult protective services instead of the 75-percent reimbursement for normal social services programs. Such a system does not force States to act, but the incentive is there because the dollars are there.

Representative **Oakar**. I know we are running out of time here. Dr. Steinmetz, I have not had a chance to read your report in detail. The members of my staff have read a lot about your work. In your study, did you do anything in terms of studying whether the instances of abuse happened most often in institutions or in the home, or was it pretty much even across-the-board?

Ms. **Steinmetz**. My study that I am doing right now is interviewing the adult children who are currently caring for an older parent or did so in the past few years. What we found in that study—and remember these are people just like you and me—40 percent of them reported screaming and yelling at their parent, 13 percent reported using some form of physical violence. How that compares with institutional abuse I cannot say because I don't have a comparable sample.

Representative OAKAR. Mrs. Roberts, you mentioned institutions and I did mention the case about a 96-year-old person being raped in a nursing home. In your experience, was the incidence of abuse more often in an institution or more often in terms of home care, or just about even across-the-board?

Mrs. ROBERTS. It was just about even across-the-board. Last year, I went out to a community residential facility where the caretaker, a woman, was caring for the elderly. I believe she had about 13 or 14 people in the home, which was reported that they were being neglected, exploited, abused. She was known to the city and they had taken her to court once. She had gone under a lot of alias names. This was reported and investigated by an inspector. The inspector said, "Well, if you write up a report and bring it to my office, we will do something about her." I hand carried my report. To date, I have not heard anything.

Representative OAKAR. Mr. Chairman, I think there is a very really important point, the fact that it exists not only in homes but in institutions, and vice versa, because I would hate to have us leave here giving the impression that it only happens in homes or only happens in nursing homes, when in fact adult abuse happens in many instances just about anywhere.

Representative PEPPER. Thank you, Miss Oakar.

Mr. Mica, do you have any questions?

Representative MICA. Thank you; not at this time.

Representative PEPPER. Mr. Gudger, do you have any questions?

Representative GUDGER. Thank you, Mr. Chairman. I have two or three questions.

I am very pleased that, under Ms. Oakar's questions, we have developed the fact that the retirement home, the nursing home, the rest home does see instances of abuse, but their licensing and supervision of licensing affords some intervention, at least in the public facility—the rest home, the nursing home, as distinguished from the retirement home.

Let me ask you this: The cases developed here have been family or pseudofamily situations. I suspect, in my State of North Carolina, we have an advantage in the considerable participation of our older population in churches, nutrition sites, and in programs which bring older people together and therefore they are able to communicate with one another about their concerns and to gain knowledge from one another as to how to deal with an emotional and stress problem within the family or the pseudofamily situation.

Would you, Mr. Bergman, comment to that? Do you see, in addition to the need to disseminate knowledge as you have developed in your previous responses, that we need to develop community participation by people of senior years so that they relate to one another, get together, and talk out their problems? Whether they do it in the church context, the Sunday school context, whether they do it in the nutrition site context, can you see any places that they can do this to deal with their problems and to become more aware of the mechanics that are available to relieve those problems?

Mr. BERGMAN. I think the answer to that question is yes to the extent that Congress has already authorized senior centers and has gone a long way toward bringing elders together out of their homes. The more you have that kind of interaction, the more people are outreached, in the vernacular, so that they are coming into senior centers and other groups, meeting with church groups, and so forth, the better chance there is of locating and preventing cases of elder abuse.

To the extent that there is education done about the problem, yes, I think it will do much to enable people to see for themselves that they are not the only persons who are elder abuse victims and that there are some ways that they can be helped. Beyond that, however, it is, I think, almost critical that there be specialized protective service workers who handle nothing but these kinds of cases. It is a high worker burnout area. If a person survives it for 6 months to 2 years, he or she has done a hell of a job as a worker because the toll is so heavy on him or her personally.

You have to have a worker who can spend 10, 20, 30 hours a week on one case at a certain point in time. So if a worker is carrying 100 cases or 150 cases, he cannot handle these abuse cases. Further, you need the funding that will allow somebody to spend that kind of time, just as you have in child abuse cases. Then if someone comes into a senior center and in one way or another admits that, "yes, it is happening to me," a protective service worker will be available to work with that person and really spend the time to begin not only getting them to say, "yes, it is happening," but, "yes, I do want to do something about it." You need both.

Representative **Gudger**. I am grateful for your earlier testimony in which you pointed out that once protective services became a matter of State law, and I suspect we have had comparable experiences in North Carolina and other States which have comparable laws, that we did find an immediate increase in the resolution of those instances of elderly abuse almost spontaneous as the public became aware of the existence of the protective mechanism.

I want to ask a question of Mrs. Roberts. Now as distinguished from my 17 western mountain counties in rural North Carolina, you are working in the District of Columbia area and you are here in a highly urban community. How do you see facilities developing that would accommodate this problem of educating the elderly who is subject to abuse to the fact that he or she has some relief available?

Let me take the point one step further to this area of concern. You are bound to have perhaps less of a church influence and less of the nutrition site community table situation than might be true in rural America. Could you comment to that? How do you pick up your knowledge of the case requiring protective care such as you are providing? How do you see a method of getting more information out of the situation where the family or the pseudofamily is abused?

Mrs. **Roberts**. I think that what we need here in the District is more communications through the media, because a lot of elderly people are homebound and those in institutions do watch TV, and a lot of them maybe cannot report because they cannot talk or whatever, they can see and they know their recourse. We have church groups, but Washington does not have enough communication now.

A good example, last year with the providers council here in the District, with the help of Adult Protective Services, we had a seminar that talked about those services available to the elderly and the need for a adult protective law. After having this seminar, we got more calls, more referrals started coming in, but our unit has only six workers and one aide. We covered a whole city, and just as this gentleman here was saying, it is like the job has burned me out. I have gotten home and answered the phone by saying "Protective Service." I think I am still on the job at home.

I go out in the field and I am on a crisis situation and I see a client there who needs help. I cannot in good conscience leave the client there in a situation on their own, so there have been nights where we have stayed out until 1, 2, 3 o'clock in the morning trying to get the problem stabilized for the client so we can go the next day and continue to work. In the meanwhile, another case may come in. You are running over here with this one, then when you don't have the moneys or the facilities or the things to work with. You cannot always work effectively.

Now chore services and homemaker service was one of the main services that we would use some time to stabilize just a little while until we could investigate a particular situation or until we can get something going maybe with a family member or other agencies, but they cut that from us. Now we don't have that. We don't have the nursing home. We don't have what you call personal care homes any more, they cut those out in the District, so now we have to resort to CRF, community placement. They will only accept people who can do for themselves.

Representative GUDGER. Thank you, Mrs. Roberts.

I have one final question if I may, Mr. Chairman.

I am so concerned about several of these situations as—take Sue out in California. There was effective prosecution to pursue this person who had obviously violated your conservator laws, who had obviously engaged in various forms of fraud and yet someone as busy as Mrs. Roberts and as busy as you, Mrs. Standley, in providing protective custody or protective care for those who are your wards and your responsibility, how can you give the time to go to court and pursue these people who engaged in these crimes?

What do we need to do to make sure that those who abuse the elderly are prosecuted and prosecuted effectively and how do we accomplish that within the limited time available to so few of you who are doing such a tremedously responsible job in an area of broad demand?

Mrs. STANDLEY. I am glad you asked that, why a social worker and not a policeman. First of all, a social worker because first we have to stop what is happening so that someone is not dead or totally impoverished. After that, we can enjoy the luxury of legal redress. Finding the key to effective prosecution is essential because senior abuse is now so easy to get away with that it is now becoming epidemic. The key to effective prosecution is early referral while the evidence is available and the trail is still hot, and that takes an educated community, and it takes laws with teeth in them.

We frequently end up where if it is a recent type of thing, if we are fortunate, we can sit down with the alleged exploiter and with the threat of prosecution hanging over them, frequently they will just give everything back if we leave them alone. If the trail is as cold as it was in Mrs. Z's situation, then the civil process is our best bet. Our district attorney can't pick up on anything that is 3 years old. The civil process is a time consuming one, so early referral and laws with teeth in them are essential and I think the local district attorneys might make recommendations about strengthening the laws about this kind of fraud.

Representative GUDGER. Thank you very much.

I assume Mr. Bergman and Mrs. Roberts would concur in these observations.

Mr. BERGMAN. Yes.

Mrs. ROBERTS. Yes, except I think we, as human beings, need to care a little bit more. I don't think there are enough people caring because with enough people who really care about the elderly, we would already have a law just as we have for the children who already have a law. We would not be sitting here talking like we are talking today, although I think this is very positive.

I think that the communication not only need to be with with the elderly, but it needs to be with all of us. We all need to care about the elderly. If we live long enough we will be elderly, become elderly. It appears that everything is focused on youth. There is nothing wrong with the youth. I have nothing against the youth, but everything today is geared toward the youth, everybody is trying to be young, everybody wants to stay young. You can dye your hair or whatever, but you will become old if you live long enough.

So I told my husband one Saturday night while sitting down and talking about things. I work until I am so depressed. You are talking about saving money for the kids to go to college; let's save some money so we won't need protective services.

Representative PEPPER. Thank you very much.

Representative GUDGER. Thank you.

Representative PEPPER. Mr. Ratchford.

Representative RATCHFORD. I think it has been adequately covered.

Representative PEPPER. Mrs. Ferraro.

Representative FERRARO. I wanted to ask Mrs. X a couple of questions because I am trying to get a profile of the person who is abused.

Mrs. X, you indicated that your daughter lived with you for 18 years, and then your husband died and she continued to live in your home, and then she started to abuse you about 3 years ago. Why didn't you report that to the authorities?

Mrs. X. I could not believe it would keep on. It was my own daughter, I just kept waiting for her to come out of it, to get better. It is a very hard thing for me to report it to anybody, and I just could not believe it would get worse.

Representative FERRARO. Your grandchildren were living in the house at the same time. Did they make any comments to their mother? Did she abuse them, too?

Mrs. X. She treated her children the same way she did me except she did not strike them, but they got a great deal of harassment. In fact, it was divided up among the three children and myself, but it was the last few months that she concentrated on me only, but the children have suffered, too. In fact, her older daughter, upon leaving the house one morning—she had all three children crying before they went to school. Her older daughter said, "Mother, you're sick," and went out and slammed the door and went to school.

Representative FERRARO. You have been out of the house for how long?

Mrs. X. I have been out since the latter part of February.

Representative **Ferraro**. Are the children still there?

Mrs. X. Well, the two daughters will be in college. The older one is in college and will start her sophomore year, the other one starts in the fall, and they won't come home very much. The older daughter, at Christmastime, had 6 weeks off and we saw her 3 days.

Representative **Ferraro**. One final question. What help is your daughter getting now that you have left the house? Is she getting any help at all with her problem?

Mrs. X. She is getting no help. She won't get help. Our doctor has tried to get her to get help. She won't admit she is sick. I am the sick one, not her. This is what she tells everybody and will not go. People are very anxious to have her go there but she won't go, she is not sick to her way of thinking.

Representative **Ferraro**. The unfortunate thing that occurs when you see that profile coming over the abuse to the children as well and then as we know the abuser, and there are many instances as an abused child that you are creating a cycle of abuse in this country unless we do something about it.

Thank you very much, Mrs. X, for your testimony.

Representative **Pepper**. Dr. Steinmetz, we interrupted you. We are running late but if you could summarize the remainder of your statement we would appreciate it.

Ms. **Steinmetz**. All I was going to point out was the data I mentioned earlier. In these families, where there is a care giver who is not psychologically ill, in most cases we still have 40 percent of them admitting to an interviewer that they scream and yell at their parent. We have 13 percent reporting that they use physical force.

I think we need to do several things. We need a comprehensive fiscal policy that emphasizes a continuum of care. We have a statute of limitation on how long you are responsible for your child, usually age 18. There needs to be some legally recognized point at which a care-giving child can say, "I ought not to be any longer totally responsible for my parent. Society should bear some of the responsibility." We tend to focus on the really tragic cases—they are easier to document, the injuries are visible, you can remove the person and you can count your successes.

What disturbs me, not only about elder abuse but other areas of family violence, are the literally hundreds of thousands of cases that go undetected because they have never quite reached that crisis point. I think one of the things we need is the community awareness. We need education to help children who are taking on the responsibility of their older parent to better understand the process of aging. We need comprehensive services emphasizing a continuum of care.

Representative **Pepper**. Thank you very much, Dr. Steinmetz.

Senator **Pryor**. Senator Heinz has a final question.

Senator Heinz.

Senator **Heinz**. Thank you, Senator Pryor.

A number of Members of Congress have mentioned today their intent to amend either the Senate or House versions of the Domestic Violence Prevention Services Act to include the elderly as an eligible population within the legislation. My question perhaps could be answered by any of those that provide protective services, but I would like to direct it specifically to Dr. Steinmetz. I encourage others to respond also should they desire to do so.

My question is, To what extent do the services to be provided by either the House or the Senate version of the Domestic Violence Prevention Services Act differ from the kinds of services that the abused elderly might need? Are there in fact differences in the kinds of services that might be needed by an abused middle-age woman and an abused elder? How concerned should we be about those differences?

Ms. STEINMETZ. I have been waiting 3 years to see the Domestic Violence Prevention Services Act passed. I think one of the things is the older people have a different need in terms of medical care, so I think there has to be a provision to recognize we may be talking about long-term care, and dealing with certain illnesses. That is going to be different.

I think the domestic violence bill also recognizes, in many cases, there are young dependent children so it can often be tied in with dependent children.

I think many of the things are needed for both populations, especially because of the cyclical effect of violence. You can't just treat one generation, you have to help all members of the family. I think we are going to find you cannot just go in and remove an abused parent. There is evidence from other areas of domestic violence that if you want to stop the cycle of violence, you are going to have to provide help to the abusers.

So I think, in some respects, a comprehensive domestic violence bill that did include elders in there would be beneficial, but I would also then like to see the moneys allotted increased. I find it upsetting that we can allocate $10 million to help Cuban refugees in Florida and we find it very difficult to add any money to help women who are living in terror in their own homes.

Representative OAKAR. Would the gentleman yield?

Senator HEINZ. Yes, happy to.

Representative OAKAR. One of the things related to the domestic violence legislation is that while the domestic violence legislation which is very, very important, protects those elderly persons living in households, it has no impact on older persons in nursing homes and other institutions, and it would not cover another point that has not really been touched on in depth today, but it would not cover exploitation, which is another form of adult abuse, and that is why it is not as comprhehnsive as other alternatives, although it is a very important piece of legislation.

Senator HEINZ. Well taken point.

Ms. Collins.

Ms. COLLINS. I would like to say one more thing about the differences in protective service programs for the elderly geared toward the elderly. When it comes to temporary housing, there is almost nothing. Shelters for battered women are shelters with younger women and children and they are not just suited to the needs of fragile, often chronically ill elderly.

Also, the court and the legal proceedings are very traumatic for the elderly persons to go through. I had a client in Boston once who was on a walker and had to go to housing court for a dispute with his landlord and he was just totally intimidated by the whole court setting. If it would be possible for judges to hear these cases privately in their chambers, which is now at the judge's discretion, it would help. In Mrs. X's case, the judge did not choose to do so and she had to go into court. We were fortunate that the courtroom was empty because it was 1 o'clock in the afternoon, but if it was 9 o'clock in the morning, she would have had to have told her story before everyone in the courtroom, which would have made it much more difficult.

The other cautionary note I would add for the protective services for the elderly is that protective service workers should be very careful about moving elderly to different surroundings because of something called transfer trauma, which means that frail elderly, when moved, have a higher mortality rate in the year or two immediately after the move. So such moves should be made with great caution and only when absolutely necessary, when no other alternatives are possible.

Senator Pryor. Thank you, Ms. Collins.

Mr. Heinz.

Senator Heinz. Thank you, Mr. Chairman.

Senator Pryor. I would like to conclude this panel by saying that in just a moment we are going to have a panel of professionals. We have had workers and I know that you are all professionals also, and we have had victims. We have heard a great deal from the workers today and I am wondering if any of the three victims that we have—Mrs. X, Mr. Jones, or Mrs. Z—after hearing the statements by the panel today, I am wondering if there is any statement that you would like to make, in conclusion or anything that you would like to add to the hearing this morning.

Mrs. X. It is important that these things are financed. I think it is the financial situation a lot of times that the elderly need and cannot get because the State cannot afford to carry them on.

Senator Pryor. Thank you.

Ms. Collins. I would just like to add one more thing about the finances of Mrs. X, as an example of the value of title III Federal funding. The program is title III funded and so is legal services, and so is the home-sharing program, which found her a new living arrangement.

Senator Pryor. Thank you.

Mr. Jones, would you like to add anything?

Mr. Jones. No.

Senator Pryor. Mrs. Roberts?

Mrs. Roberts. No.

Senator Pryor. Mrs. Z, we have not heard from you this morning. We have heard very eloquent statements by your friend Mrs. Standley. Mrs. Z, would you like to make any statement at this time after hearing the testimony?

Mrs. Z. Yes; it makes me angry that all my jewelry was taken over by this woman and my husband's jewelry was taken over, and I have never been able to get a pin out of her, and I don't like that.

Senator Pryor. You did report that this jewelry was taken from you?

Mrs. Z. Oh, yes.

Senator PRYOR. And Mrs. Standley knows that the jewelry was taken from you?

Mrs. Z. Yes.

Senator PRYOR. What rights does a person like Mrs. Z have, Mrs. Standley, to obtain her property?

Mrs. STANDLEY. We can trace the title to a house, but after 3 years have gone by, even things with monetary value like jewelry cannot be legally returned without some tangible evidence besides Mrs. Z's feelings and statements. Things that don't have actual monetary value, like family pictures, clothing, and keepsakes can never be replaced.

Senator PRYOR. Is it true that you actually saw this person Sue wearing your jewelry? Is that correct?

Mrs. Z. Yes, I did. She had a ring on one time and I accused her of it and she said it was not hers. I said, "Well, of course you never had one and you don't have it now," but I couldn't get it out of her.

Senator PRYOR. Was that your wedding ring or engagement ring?

Mrs. Z Yes, and she took my husband's ring. My husband had a valuable ring, two of them. One is a blue-white stone and the other is a diamond, and she just took those. I had them in a little leather purse. She took the whole thing and I never could get her to give them back to me. Of course, I didn't know much about it while she was doing it either.

Mrs. STANDLEY. If a person such as Mrs. Z becomes ill and is hospitalized, there really is no provision for protection of assets and possessions unless somebody makes a referral for someone to move in and protect their possessions and home during the time of the incapacity.

Senator PRYOR. The thousands of people like Mrs. Z who lose property and subsequently become hospitalized, don't they basically lose credibility at that time? In other words, they say, well, they are old or they are sick, or they are paranoid, or they are all mixed up. Isn't that often the case?

Mrs. STANDLEY. That is very often the case, and when a person has white hair and a physical illness, it is immediately assumed that they must be a little off their rocker, too, especially if they don't like what is going on.

Senator PRYOR. Thank you.

We have seen from panel No. 1 the examples of emotional abuse, financial abuse, physical abuse, and psychological abuse. We want to sincerely thank those who have participated on this panel and have worked with the professionals, and certainly the victims who have come forward in great courage and have given us this testimony this morning. We hope that we will utilize the testimony, use it wisely, and react accordingly, so that we might legislate in the best of the American tradition in attempting to come to grips with this problem.

Representative PEPPER. I want to join in the warmest way with what has been said by Chairman Pryor. We can never forget your appearance here today and what you have said. We hope it is going to have some permanent impact on legislation of the Congress and the States of the Union, and it may favorably impact many lives of other people like you who have been victimized or abused.

Thank you very much.

Senator PRYOR. We will ask this panel to retire now and the other panel to come forward. Thank you so much.

[Whereupon, a brief recess was taken.]

Senator PRYOR. Ladies and gentlemen—I started to say good morning but it is this afternoon. By the way, I have been up all night. The Senate did not adjourn last evening, so I have been up all through the night. I had a little catnap on my sofa in the office, so if I don't make good sense that is just one of the reasons, there are several others.

We will now hear from our second panel. Our first witness will be John J. Regan, dean, Hofstra Law School.

Mr. Regan, you are not related to Ronald Reagan?

Mr. REGAN. No.

Senator PRYOR. You may want to change your name or the pronunciation around here before long. I am not saying I advocate that, being a good Democrat.

Mr. Regan has served on the American Bar Association's committee dealing with problems of the elderly. He has been on the board of directors of the National Senior Citizens Law Center since 1975, and he is doing extensive work in this area. I could go on and on and list many other outstanding things that he has been involved with.

Our second panel member is R. Bryan Tilley, legal services developer with the office of aging in the State of Arkansas. He has assumed responsibility for and directed the Arkansas protective service program. He will discuss the adult protective services law.

The next member of the panel is Thomas Mahoney, commissioner of the department of elder affairs in the State of Massachusetts. He has served as commissioner while on leave from the Massachusetts Institute of Technology, where he has been a faculty member since 1945. He served in the Massachusetts State Legislature for four terms, and has long been an advocate for the elderly in that State. Mr. Mahoney will discuss a bill pending today in the Massachusetts Legislature which he helped to develop.

Mr. Mahoney will be followed by Elizabeth Lau, who is supervisor of a direct service system at the Chronic Illness Center in Cleveland, Ohio, where she has worked for 10 years. She recently completed a study on abuse of the elderly and determined almost 75 percent of those cases involved physical abuse and over 50 percent involved psychological abuse. She will expand on the details of her study and suggest some remedies.

Our final panel member is Mary Hill, assistant administrator of Century Home, Inc., in Baltimore, Md., which is an 82-bed home in the inner city of Baltimore. Mrs. Hill has been a registered nurse since 1943. She worked with the mentally retarded in the District of Columbia from 1969 to 1978, when she became the assistant administrator at that time. She will testify about the financial exploitation by relatives of patients in her particular home. She knows firshand about particular and specific events.

All of the panelists today are going to have the privilege of submitting their entire statement for the record if you so choose. I am going to ask each member of the panel to summarize their statement and hold that summary to 4 minutes, and then we will have the opportunity to submit those statements for the record, to be printed in full, and also to ask each panelist specific questions.

Representative **Pepper**. I have not had the privilege of knowing all of the members of this panel, but I have had the privilege of working closely with Dr. Mahoney of Massachusetts, under his great Governor, who is so very much interested in the problems of the elderly. I am personally pleased to see Mr. Mahoney here, as well as the other members of the panel.

Senator **Pryor**. You may proceed, Mr. Regan.

STATEMENT OF PROF. JOHN J. REGAN, HEMPSTEAD, N.Y., DEAN, HOFSTRA LAW SCHOOL

Professor **Regan**. Senator Pryor, Congressman Pepper, members of the Senate and House committees, 3 years ago, I helped prepare for the Senate Special Committee on Aging a working paper and model State legislation[1] dealing with many of the issues discussed today. That was entitled "Protective Services for the Elderly." I welcome the opportunity to discuss with you briefly today some of the legal aspects of the problems of dealing with elderly abuse, whether that be caused by abuse from others, neglect from others, or self-neglect. I propose to focus on legal approaches to mitigate the problem, rather than adding to earlier testimony about the nature and scope of the problem, or about the type of service required.

Protective services involve not only service delivery but the actual or potential intervention of State authority into the life of an elderly person. Typically, when a person wants to delegate to another the power to act for him, he does so through some instrument such as a power of attorney or through joint ownership of the adult's assets. Sometimes, however, in protective services programs, adults resist cooperation with the caseworker, in spite of their apparent need, either because they simply don't want help or because of failing mental capacity or physical deterioration. Intervention, whether it be voluntary or, in the latter case, involuntary then, becomes a serious problem for government.

To deal with this problem, protective services laws across the country—and I count almost 20 at this time—may authorize a public or private social services agency to initiate guardianship or conservatorship proceedings, which then lead to the appointment of an agency or some private party as guardian. In emergency situations, some of these laws also create special court proceedings which lead to the appointment of a temporary guardian may then authorize needed medical treatment.

Most States, however, lack adult protective services laws, and in those jurisdictions public agencies desiring to intervene involuntarily are resorting to the ordinary guardianship law of the State, falling back on emergency civil commitment laws, relying on theories of implied consent for medical treatment, or even using the arrest power of the police to accomplish intervention. All of these alternatives may result in inappropriate intervention or even serious violations of the clients' constitutional and civil rights.

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[1] See appendix 2, page 148.

Passing a protective services law is no guarantee, however, that the needs of the abused elder will be met or his/her rights respected.

The lack of mandatory reporting and immunity provisions has already been mentioned today, and certainly that gap ought to be filled. However, many State laws are a little more than reporting laws and do not provide the necessary and adequate followup on the service level to make the reporting law worth the effort of passing it.

More than that, some of these laws now are authorizing a great deal of involuntary intervention but are appropriating little or no money to provide the services necessary to deal with the client's needs. In addition, many other States are relying on guardianship and conservator laws drafted in the 19th century to determine whether involuntary intervention should occur. These laws are seriously defective in their criteria for identifying incompetent persons, in their failure to provide even a minimum of due process for the client, in their overbroad delegation of power over the client to the guardian, in their demoralizing effect on the client, in their blindness toward conflicts of interest between guardian and ward, and in the lack of supervision given the guardian's treatment of the ward.

In addition, many State laws fail to deal with emergency medical situations and thereby allow the hasty and often inappropriate admission of the elderly client into a State mental hospital or other infringements of civil rights.

Finally, some are permitting the creation of public agency guardianships, thought to be a major improvement, but without paying sufficient attention to the resulting depersonalization of the guardian-ward relationship that results when a large agency becomes guardian of an elderly client, or indeed to the conflicts of interest which are inherent in a public guardianship.

Let me propose a few steps which the Federal Government might take in helping to develop protective services, but at the same time to properly control them. Preliminarily, there is an important Federal role, it seems to me. The welfare of the elderly, whether institutionalized or not, is as much a matter of Federal concern as the welfare of any other vulnerable and needy group in our society.

More than that, there are important civil and constitutional rights at stake here which need protection, and it is uniquely the role of the Federal Government to assure the protection of those civil rights. The elderly client has neither the capacity nor the means to challenge an invasion of his rights.

Third, title XX of the Social Security Act and title III of the Older Americans Act have already put the Federal Government into the business of providing protective services, but without the necessary guidelines for protecting interests of the clients served by those programs.

Finally, of course, the Federal role is preeminent in removing the bias toward institutionalization which permeates Federal health care programs.

Therefore, I propose a few modest steps. First, as has been mentioned already today by others it seems necessary to amend title XX to encourage the States through various kinds of incentives to enact appropriate protective service legislation. Moreover, there ought to be added to title XX, and to title III of the Older Americans

Act for that matter, a requirement that States utilizing funds derived from those programs comply with Federal conditions of participation.

These conditions, which would be mandated by congressional action and developed through regulations would set forth standards for intervention, which States would be required to observe as a condition for using the Federal funds provided through an adult protective services program. The purpose of these conditions would be to protect the civil and constitutional rights of the clients served by these programs. Thus, for example, these conditions might establish minimum procedural criteria for State proceedings, which are used to implement the decision by an agency to seek involuntary intervention, or they might similarly develop guidelines for public agency guardianships.

I might mention, incidentally, that the American Bar Association's Commission on Legal Problems of the Elderly is currently working on just such a project; that is, to propose minimum standards for State guardianship and protective services legislation.

I also suggest, based upon strong impressions received from contact with social services personnel in the Eastern States at least, that there is very little communication among agency personnel in the various States who are attempting to develop local laws and programs, and that the experience that many have is not being shared with one another. Therefore, it seems to me that the moneys, and they need not be great, could well be built into title XX and title III to provide national, regional, and local training programs in this area so that a healthy interchange of information among the States could proceed.

There are many other recommendations which I might make but I will not burden you with them at this moment. I appreciate the opportunity to have shared these views with the committees.

Thank you.

[The prepared statement of Professor Regan follows:]

PREPARED STATEMENT OF PROF. JOHN J. REGAN

I am John J. Regan, Dean of Hofstra Law School in Hempstead, N.Y. Three years ago, I helped prepare for the Senate Special Committee on Aging a working paper and model State legislation on "Protective Services for the Elderly." I welcome the opportunity to discuss with you the legal aspects of dealing with abuse of the elderly, whether caused by the abuse or neglect of others or by self-neglect. I shall focus on legal approaches aimed at mitigating the problem, rather than adding to earlier testimony about the nature and scope of the problem.

In response to the problem of abuse of elderly and mentally handicapped adults, about 20 States have enacted so-called adult protective services acts over the past 6 or 7 years. Protective services, a euphemism borrowed from the child protection area, is traditionally defined as a system of services—preventive, supportive, and surrogate—aimed at the elderly living in the community for the purpose of enabling them to maintain independent living (thereby avoiding unnecessary institutionalization), while at the same time protecting them from abuse and exploitation. Protective services involves two components: the coordinated delivery of a wide variety of social and health services, and the actual or potential legal power to intervene involuntarily in the client's life and thereby make personal care or asset management decisions for that person.

Ordinarily, an adult who wishes voluntarily to delegate to another the power to make personal decisions executes a power of attorney or gives the delegate joint ownership of the adult's assets, for example, through a joint bank account. However, some elderly clients served through adult protective services programs may resist cooperation with the caseworker, in spite of their apparent need for help, either because they do not want the help or because failing mental capacity prevents them from appreciating their need, or because significant physical deterioration (e.g., through malnutrition) has created a medical emergency with which they cannot cope.

To deal with such resistance, protective services legislation may authorize a public or private social services agency to initiate guardianship proceedings leading to the appointment of the agency or a private party as guardian. For emergencies, the law may create a special court proceeding leading to the appointment of a temporary guardian who may then authorize the needed medical treatment. In States lacking adult protective services laws, the agency may still resort to regular guardianship proceedings or fall back on emergency commitment laws, theories of implied consent for medical treatment, or even the arrest power of the police as ways of accomplishing intervention.

Dealing with the problem of the abused elder presents a classic case of an age-old tension: how to reconcile society's desire to protect its vulnerable citizens while at the same time respecting their civil rights, particularly their rights to liberty, privacy, and autonomy. At stake here are, on the one hand, the State's right as parens patriae to intervene, and, on the other, the individual's right to give informed consent to the receipt of social and medical services. Proposed legislative solutions must likewise give attention to the developing constitutional principle that involuntary intervention by government in the lives of its citizens be as little restrictive of liberty as is consistent with legitimate legislative goals and the welfare of the individual.

The flurry of legislative activity over the last few years has produced protective service laws of uneven quality. Let me list a few of the more frequent defects:

(1) Some State laws are little more than reporting laws (those mandating that citizens report cases of adult abuse to public agency).

(2) Some authorize a great deal of involuntary intervention but appropriate little or no extra money to provide the services needed to deal with the client's needs.

(3) Many rely on guardianship laws drafted in the 19th century to authorize the intervention. Often these laws are seriously defective in their worthless criteria for identifying an incompetent person, in their failure to provide even a minimum of due process for the client, in their overbroad delegation of power over the client to the guardian, in their demoralizing effect on the client, in their blindness toward conflicts of interest between guardian and ward, and in the lack of supervision given the guardian's treatment of the ward.

(4) Some fail to deal with emergency medical situations, thereby allowing hasty and often inappropriate admission of the client into a State mental hospital or other infringements of civil rights.

(5) Some permit the creation of public agency guardianships without paying sufficient attention to the resulting depersonalization of the guardian-ward relationship or to the conflicts of interest inherent in such guardianships.

What steps are needed to correct these problems, and what should be the role of the Federal Government in developing protective services? Before suggesting some answers, let me state why I believe there is a Federal role:

(1) The welfare of the infirm elderly, institutionalized or not, is as much a Federal concern as the welfare of any other vulnerable and needy group in our society.

(2) Important civil and constitutional rights are at stake, which are often invaded by private citizens, public agencies, and even the courts, but judicial review is unavailable because the client has neither the means nor the capacity to challenge the invasion.

(3) Title XX of the Social Security Act and title III of the Older Americans Act have already committed the Federal Government to financial support of State protective services programs but without any real guidelines for protecting the interests of their clients.

(4) Federal action is needed to reduce the bias toward institutionalization which permeates Federal health care programs.

My chief proposal for dealing with the legal aspects of the problems of elderly abuse is that Federal agencies administering title XX (Social Security Act) and title III (Older Americans Act) programs be required to develop through regulation so-called "conditions of participation" for States and area agencies. These "conditions" would set forth standards for intervention which States would be required to observe as a condition for using Federal funds for an adult protective services program. The purpose of these conditions would be the protection of the civil and constitutional rights of the clients served by such programs. Thus, for example, these conditions might establish minimum procedural criteria for State proceedings used to implement a decision by an agency to seek involuntary intervention in a program client's life. Similarly, guidelines for public agency guardianships could be developed. Incidentally, the American Bar Association's Commission on Legal Problems of the Elderly is currently working on a project to propose minimum standards for State guardianship and protective services laws.

I also have the strong impression, having spoken with social services agency personnel in many Eastern States, that little communication about the common problems of developing adult protective services programs is occurring. Many State agencies and legislatures are still reinventing the wheel in this regard. It is also evident that the common experience with such programs is not being shared and analyzed. I therefore recommend that moneys be appropriated, and they need not be great, to provide national, regional and local training programs in this area, sponsored by or contracted for by the Administration on Aging.

There are other recommendations to be made which I am sure you have heard before but which I shall briefly summarize:

(1) Medicare should be expanded to provide coverage for in-home health services to a greater extent than it does now.

(2) Community mental health centers should be required to devote greater attention to the elderly.

I appreciate the opportunity to present my views to the committees, and I shall be happy to answer any questions you may have.

Senator **Pryor**. Before we ask questions of the witnesses let us continue on and complete your statements.

Mr. Tilley, would you please summarize your statement.

STATEMENT OF R. BRYAN TILLEY, LITTLE ROCK, ARK., LEGAL SERVICES DEVELOPER, OFFICE OF AGING, STATE OF ARKANSAS

Mr. **Tilley**. Mr. Chairman, distinguished members of the committee, I will be brief. There are a few points I would like to offer for your consideration.

Arkansas in 1977 adopted an adult protective services statute. It is a fairly good statute in terms of it has mandatory reporting. There are sanctions if you don't report cases of suspected abuse. The only problem was there was not any money appropriated for it. In 1979, the State legislature appropriated $100,000, and for the first time the service was offered on a 24-hour-a-day, 7-day-a-week basis.

The statistics are interesting. We looked at, by the way, in 1979, the responsibility for implementation of the statute that was moved to a different State agency where I am involved, and we looked at the first 2 years of operation in order to anticipate what the caseload would be. We predicted perhaps 300 cases per year that would be reported and we would have to investigate. During the first 5 months of operation, we found that we had opened over 320 cases. We are projecting for the end of the year between 1,000 and 1,200 cases.

Another interesting statistic is when we first looked at the number of substantiated cases that we had investigated, we were looking at maybe 5 percent. It has been our experience that the number of substantiated cases is going to be 15 to 20 percent of those we investigate. I would like to quickly emphasize that we have not advertised the service in Arkansas, one only learns about it through word of mouth through the State agencies, and so forth.

The cases we have are very typical to the ones that were mentioned this morning. However, the No. 1 problem in Arkansas are cases of self-neglect. I don't believe that any State nor any political body ought to impose its moral values on any individual. I think the State does owe a duty to its citizens to protect their health, welfare, and safety. The problem is where do you draw the line? In Arkansas, we go to a system, we use the judiciary, and these cases are very time consuming.

One last point. I think the mechanics of an adult abuse statute ought to be primarily a State law consideration. It takes all the resources a State has, it takes a myriad of State agencies and service delivery systems, working together, in order to solve the myriad of problems you have protecting an older person but I think the Federal Government can provide the guidance and, I think, as you heard this morning, the money.

Thank you.

[The prepared statement of Mr. Tilley follows:]

PREPARED STATEMENT OF R. BRYAN TILLEY

Mr. Chairman and distinguished members of the committee, I would like to thank you for giving me an opportunity to testify on this very important topic.

Before I share a couple of case histories with you I believe it would be important to briefly sketch the background of the adult protective services statute in Arkansas.

The Arkansas adult protective services statute was originally enacted by the State legislature in 1977. Unfortunately, no money was appropriated for the provision of this service and during the first 2 years utilization of the statute was less than effective. In 1979, with the strong support of Gov. Bill Clinton, the Arkansas General Assembly made two changes; they moved responsibility for implementation of the act to the Office on Aging and they appropriated a little more than $100,000 to provide the service. With this new funding, four staff persons were employed to do this service for the entire State, and for the first time the service was offered on a 24-hour-per-day, 7-day-per-week basis.

The statute carries with it a tremendous responsibility and a lot of power. While as a matter of office policy we always strive to use the least restrictive alternative, in extreme cases the statute authorizes us to take someone into involuntary protective custody for up to 3 days. We have set up a system designed to safeguard against indiscriminate use of involuntary protective custody, however, we do use it as a tool to do our job.

In designing a mechanism to carry out the various phases of this service, we first looked at existing records to anticipate caseload. We projected that we would have 300 cases during the first year of operation, with approximately 95 percent of the cases being unsubstantiated. Obviously, unsubstantiated cases require much less time. Our actual experience turned out vastly different than expected, during only the first 5 months of operation, we opened approximately 320 cases, but even more astonishing was the fact that the number of substantiated cases was much higher: approximately 20 percent as compared to the 5 percent we were expecting. We are anticipating in excess of 1,000 cases in the first year of operation with 15 to 20 percent of these cases being substantiated. I will quickly point out that because of our limited resources we have not advertised this service. The existence of this service has been strictly advertised by word of mouth.

What kinds of cases do we encounter? In Arkansas, self-neglect seems to be the greatest problem we encounter. Family abuse and neglect seems to be the second major problem we encounter. All these cases are tough. I don't think that the State of Arkansas or any other body politic ought to impose its moral values on anyone, however, I do believe a State has a duty to protect the health, safety, and welfare of its citizens. The problem many times is where do you draw the line.

The very first case handled is a good example of a typical self-neglect case. This case involved a woman from Ft. Smith in her mid-80's. This woman wandered the streets aimlessly and reportedly almost blew herself up by failing to turn off her gas oven. When investigating this case, the protective services consultant discovered that the woman was not oriented to person, place, or time, that she did wander the streets at all hours of the day and night, which was very dangerous because she was nearly run over several times. We also discovered that there was no family. We first counseled with the woman, trying to convince her that she needed to check herself into a nursing home where she would have a warm, dry place to sleep, three square meals a day, and lots of friends. We were unsuccessful and had to go to court to get an order for long-term protective custody. Fortunately, in this case, the lady was eligible for medical assistance program to pay her nursing home bill. But getting the lady admitted to the nursing home was not the end of the case. We had to inventory and arrange for the disposition of what few assets she had and report to the court every few months on her condition. Twice while in protective custody we have authorized surgery on this woman, and I am pleased to tell you that she is doing fine and is very well adjusted to her new home.

The second case is one of actual physical abuse and neglect. The report came in from hospital staff in Little Rock. It seems that this was the third time this woman in her mid-fifties had been in for plastic surgery. She was a paraplegic as well as being of questionable competency. Her husband was "taking care" of her. It turned out his real motivation was getting her disability check each month. He did not work and drank very heavily. Needless to say, this fellow knew that if he placed his wife in an institution, which had the capability to properly take care of his wife, he would lose his drinking money. He carried her around in the back of his pickup throughout his daily activities. The sad fact was that he would leave her in the truck while he would go in the local pool hall and drink beer. The husband, having a vested interest, was prepared to fight for custody of his wife and her SSI check. Unfortunately, this case has somewhat of a tragic ending. While the wife was recovering in the hospital, her husband burned himself up in the house trailer where they were living. She was then willing to go to a facility where she could be taken care of properly.

Unfortunately, we have learned that in most cases of abuse and neglect in the family, money is the motivator.

What should be the Federal role? I think the mechanics of any adult abuse statute is essentially a State law consideration. After all, it is up to the State to protect the health, safety, and welfare of its citizens. I think the Federal Government should provide motivation and guidance in the development of adult protective services programs. Particularly in States like Arkansas, which have extremely limited resources, seed money for the development of these programs would be crucial in dealing with the problems of adult abuse and neglect. It is not difficult to imagine a State assuming responsibility for an adult abuse program which had illustrated to State officials the scope of the problem in that State.

Senator PRYOR. Mr. Mahoney.

STATEMENT OF THOMAS H. D. MAHONEY, PH. D., CAMBRIDGE, MASS., SECRETARY, MASSACHUSETTS DEPARTMENT OF ELDER AFFAIRS

Dr. MAHONEY. Thank you, Mr. Chairman, and distinguished cochairman. I deeply appreciate the opportunity to appear before you this morning. I am especially thankful for the very generous remarks of Senator Pepper.

In Massachusetts, the Department of Elder Affairs is the State's public advocate for elderly citizens and we are responsible for the development of a comprehensive and coordinated system of services for the elderly.

At present, protective services for the aged are included within such programs as those supported by title XX of the Social Security Act, designed to protect an older person from himself or another individual. Services to those persons may include home health or medical assistance, homemaker, nutrition, transportation, counseling, or legal assistance to expedite a change of setting or guardianship.

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In addition, we have established our nursing home ombudsman as part of the State's advocacy assistance program to provide the basic elements of protective services to the institutionalized.

However, over the past 15 months, we have discovered that the need for elderly protective services runs much deeper. The Department of Elder Affairs of Massachusetts commissioned a study to examine the scope of the abuse problem, and the findings challenge those working with the elderly to develop new and effective means of aiding abused older persons.

While I take no pleasure whatsoever in reporting our findings to you, I believe that it is essential that the public be informed of the serious problem that we have uncovered in Massachusetts. The study that we commissioned some time ago brought out the existence of elderly abuse, particularly in an urban setting.

Of over 1,000 professionals and paraprofessionals asked to respond to inquiries, one-third of those participating indicated an awareness of an incidence of abuse of an elderly person within the previous 18 months. Their data are shocking.

Physical and emotional abuses tend to be recurring events, rather than isolated incidents. While most of the victims are women, more are likely to be over 75 than between the ages of 60 and 75. In 75 percent of those cases, the abuser resided in the same household as the older victim, and 84 percent of the instances of abuse were committed by family members.

However, the problem is more complex than simple statistics, particularly when the sensitive issue of family relationship is involved. In over half of the cases, the physical and emotional needs of the elderly person contributed to the family stress and resulted in some form of abuse. In some cases, the financial dependence of the aged person was a factor, though it is not uncommon to find the abuser, himself, a victim of financial difficulties, physical problems, or dependence upon drugs or alcohol.

In addition, while some cases are clear and offer an optimal treatment plan, others are difficult to identify. A physician reported to us of a case in which a middle-aged woman accompanied her badly bruised mother to a Boston emergency ward, once there, she pleaded with the attending physician, "Please help me, doctor; I'm beating my mother."

Others are not willing to come forward. An elderly gentlemen was admitted to a Boston hospital with double leg fractures, claiming to have fallen down a flight of steps, yet, pleading to be placed in a nursing home. His social worker was able to determine in a short time that this old man had been pushed by his alcoholic grandson whom he had denied a small loan. Needless to say, his placement was expedited.

A third case was reported to our offices only last week. An elderly woman, emotionally disturbed and confined to her bed, was discovered by a visiting nurse unclad, hungry, and incontinent. The door to her refrigerator was padlocked. Her room was poorly lit. No one had attempted to feed or clean this woman for at least 4 days. Her husband, and a son who did not live with his parents, were well aware of the condition. The local police chief was notified, and the victim was hospitalized, suffering from malnutrition. However, all three in the family showed clear signs of emotional disturbances. Procedures are presently underway to provide counseling for the family while a placement is sought for the victim.

Although the report is only a first look, it provides evidence of abuse. We have learned that it is occurring in all neighborhoods of our Commonwealth and in our strata of society.

We think that it is sufficient to begin the process of developing corrective legislation and in doing this we set as our primary goals the protection of the individuals and the encouragement of "the family." What we have attempted to do is to provide for protective services and the investigation of abuse without delay. Criminal prosecution does, of course, remain an option for the proper authorities, but respect has to be paid to the "family unit" where various social service programs and counseling may be more appropriate in the long run.

In February of 1980, we joined with a number of other proponents of elder abuse legislation in our State and we developed an "omnibus bill." We took the best points of several differing proposals to unite elder advocates in a single voice before the legislature of Massachusetts. This was a very rewarding and extraordinary experience and tribute to the fundamental concept of compromise. The legislation came from such disparate service as my office, the secretariat of elder affairs, the attorney general, one of the district attorneys, and various members of the legislature.

We had some 10 bills, and we put them together in the best democratic process of compromise—in the right sense of the word—and we came up with what called the Massachusetts Elder Protection Act. This provides a reporting procedure for suspected cases of abuse directed to a centralized office, with responsibility to investigate, located in our department, the Department of Elder Affairs.[1]

This is a very tall order and we appreciate its complexities. Agreement on definitions of terms, reporting relationships, listings of mandated reporters, and penalties for failure to report instances of abuse, were developed after very extended discussion as a possible compromise solution. Each item is very important to the agency which has to implement the program.

There are numerous problems in drafting any piece of social legislation of such major proportions. After we found the existence of abuse of our elderly citizens, a critical social problem which, of course, demands urgent attention, we prepared an analysis of legislation in the other States.[2]

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[1] The investigatory process is reserved to the Department of Elder Affairs in all all areas of abuse, except those involving health care. Where health care facilities or licensable health services are involved, both the Department of Elder Affairs and the Department of Public Health, at the request of Elder Affairs, will investigate independently. The two departments will consult and reach a mutually satisfactory and agreeable conclusion as to the justification of the complaint(s).

In areas other than health, the Department of Elder Affairs will reach an independent conclusion on the justification of the complaint.

[2] The concept of what the general welfare requires in order to fulfill the needs of the public to have their government provide for those services they cannot provide for themselves, has historically been subject to changes over the years.

Forty-five years ago, for example, the Nation was in the midst of an economic depression, struggling to find new governmental devices to cope with the difficulties. In 1935, the social security system was enacted, based, to some extent, upon social security programs developed by Bismarck in Prussia in the latter part of the 19th century. The law was immediately challenged, and eventually, subjected to judicial review. While the Supreme Court had considered the "NRA" unconstitutional and had struck down other "New Deal" proposals, the Social Security Act passed constitutional muster. The words of Justice Cardoso are of particular importance. Speaking for the Court he said:

". . . nor is the concept of the general welfare static. Needs that were narrow or parochial a century ago may be interwoven in our day with the well being of the Nation. What is critical or urgent changes with the times." *Helvering v. Davis* (301 U.S. 619, 1937).

We concluded that a bill which facilitated the reporting and the investigating of abuse was the best approach. As incidents of alleged abuse are reported and evaluated, we hope to acquire the necessary experience to determine the most effective protective services for our needs.

We all agreed that the key to a reporting law is to provide immunity to the individuals who make a report and, then, to insure the promptness of a thorough investigation. Our "omnibus bill" imposes civil penalties, including fines, for failure to report knowledge of abuse. Those mandated in the report include licensed professionals in the health field and in the allied social service fields. In addition, executive directors of home health, homemaker, and long-term care facilities themselves mandated reporters, have to develop mechanisms within their agencies and institutions for their employees to report instances of abuse.

We agreed that information relating to cases would be handled confidentially, available only to those with a legitimate need to know.[3]

A major issue in all of this, of course, is the determination of capacity of the victim of abuse to make a competent decision. The very sensitive relationships which may exist within the confines of the family are critical. We have heard repeated this morning what we have previously known, namely, that many victims are reluctant to take any action where the abuser is a family member. We recognize also that, in many cases the abuser is obviously as much in need of help as the abused.

We have also identified a need to provide an emergency authorization to relocate, at least temporarily, those that suffer critically. We must develop relocation hostels. That was brought out earlier but I would reiterate it as a very important element here, at least on the basis of short-term placement. We need legal authorization to remove incapacitated victims from their homes in certain circumstances.

As I will note later, the critical shortage of adequate housing for the elderly exacerbates the problem, not only in clear abuse cases, but also in cases where the older person is the cause of family stress for lack of a more appropriate place to reside.

The issue of self-neglect is one requiring special consideration. Legislation too strictly constructed may impose upon those individuals who, out of conscious, personal choice, may wish to neglect their own personal standards of housekeeping, health, or nutrition.[4]

We believe strongly that there is a need for the delegation of some discretion to the administrative agency within State government in developing a workable protective services program. There are both advantages and disadvantages in setting forth details in legislation with exactness. However, in the delicate areas, such as abuse within the family, it appears the course of wisdom to proceed with caution, and to develop regulations based upon experience.

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[3] In instances where it appears that there is a lack of capacity to properly determine such a question, or to make decisions to establish a better protected life style, it is essential, under our laws, that a court make a determination, and that a court approve the determination of incapacity and the appointment of a caretaker or guardian.

[4] It is also important to note that the investigation of reports of abuse may impinge on constitutional protections in the field of criminal law. Our department believes that, in ordinary cases, it can confine itself to a social services provider role within the requirements of *Wymen v. James* (401 U.S. 309 1971). This important case differentiated the public need to check homes to insure that welfare assistance was appropriately delivered from the search warrant requirement imposed upon law enforcement officials investigating a possible violation of criminal laws.

It is not wise to build hopes that are impractical, to mandate provisions which are impractical would thwart the intent of the legislation and the joint efforts of many dedicated elder advocates.

In conclusion, we would like to recommend several ways in which the Congress and the Federal Government could be of assistance in this area.

First, we feel that the Federal Government, as the repository of some data on this subject, ought to make as much of this information available in a helpful form to the State agencies. We need an informational structure that respects the privacy of the individuals. We feel that is essential.

Second, along this line we encourage and we applaud the services of this distinguished joint committee and, in particular, publications such as the working paper which was prepared by the Senate special committee in July of 1977 dealing with the protective services, and for the various publications that have come out of the House side as well.

Third, training publications should be developed which could be used by the State agencies to prepare protective service workers in both the public and private sectors.

Fourth, the Federal Government now funds a nursing home ombudsman to handle complaints relating to long-term care facilities. This same kind of eligibility for funding should be made available in order to assist the States in establishing programs to receive reports and to undertake investigations of elderly abuse. Let me say, parenthetically, that we estimate, in a State the size of Massachusetts—and we are only 10th in population—that it would cost $3 million to get this kind of program underway, and that would be just the beginning as far as costs are concerned.

Fifth, again, it is unfortunate, but social abuse has been found within all peoples at almost all times, and history and literature are filled with very rich examples. There is some indication that modern society has permitted the increase of family tensions, and the family violence may have proportionately grown. If this is so, the Federal Government, we think, should survey the effects of governmental programs, procedures, and priorities in programs from the funding of government programs, to the shortage of decent housing for the elderly, to tax deductions for elderly dependents in order to insure that no statute, no regulation, no policy of the Federal Government or, for that matter, any other branch of government is a likely source contributing to the incidence of abuse.

Along this line, I would like to commend the members of the committee who have expressed their support for the inclusion of adult day care among medicare eligible reimbursable services. In a great many cases, family stress is made much more severe when members have to remain at home to take care of an older person throughout the entire day. Extending eligibility would bring this very fine service within the reach of many and would allow family members to enter the work force in a number of instances. Some of the most frequent cases of abuse, that is, stress and resentment, could be removed.

I would like to make clear this is only one of many commendable arguments on behalf of adult day care centers. As Congressman Ratchford of this committee, with whom I had the pleasure of serving on the National Conference of State Legislators, has so articulately stated, the possible elimination of the disruption of the life of family members and the general easing of tension and anxiety is a very persuasive argument on its own.

In conclusion, I wish to thank you again for this opportunity to represent the Massachusetts Department of Elder Affairs before this very distinguished committee and its distinguished cochairmen.

Senator PRYOR. Thank you, Dr. Mahoney.

Ms. Lau.

STATEMENT OF ELIZABETH LAU, CHRONIC ILLNESS CENTER, CLEVELAND, OHIO

Ms. LAU. Mr. Chairman, I would like to thank you for the opportunity to speak to you today. I will try very hard to summarize in 4 minutes.

I did a study in 1978, and at that time there had been no research whatsoever which focused on abuse of the elderly. I had been working as a protective service worker for 10 years and I am primarily a practitioner, but I am also interested in research. We looked at our client population of new cases over 60 for a 12-month period and found that almost 10 percent of our clients, a total of 39, had been abused in some way. We found that 30 were women, 21 were widowed and 29 were white. Twelve lived alone, nine with a spouse, and the rest with children, grandchildren, or other relatives. The majority lived in private homes, the homes of the people who abused them, in the city, in boundary suburbs, and in outlying suburbs.

They were from all geographical, racial, and economic groups. Over three-quarters of these people had at least one physical or mental impairment. Some were impaired in ambulation, some in hearing, some in vision, some were partially or totally incontinent, and 41 percent were confused. We have heard people speak about day care services and senior centers. A lot of these people are homebound and have no access to other human beings or any other kind of social programs.

We feel that probably our sample was underreported because we were using case workers' memory to identify those abused persons. Only 15 percent of our people were abused in only one way, 72 percent were abused in two to five ways. We included physical abuse, severe neglect, psychological abuse—including verbal assults, threats, isolation, and material abuse which we have heard about today called exploitation, theft, or misuse of money, belongings, or property. Others had their rights violated by being forced to move from their residence to a nursing home or other residence.

Most often, the abusers were the relatives upon whom these abused persons were dependent for care and/or assistance. In many cases, the abusing persons had problems of their own, including retardation, mental illness, and alcoholism. What we saw was behavior which occurs under the stress of overwhelming, unrelieved care responsibility following a long history of family problems, conflict, or family violence.

I have a few cases that I would like to cite. I will try to be very brief.

We had one lady, 83, who was in a wheelchair and had expressive aphasia. This woman was beaten with a hairbrush by her care-giving sister to punish her for incontinence and disobedience. The sister has raised 10 children and had harshly disciplined them, many of whom had been in juvenile court. Despite the beatings, this client repeatedly expressed a clear wish to stay at home where she was always with family members, with a granddaughter and with a family dog that she was very fond of. We supported her with our social work, home aide, medical and nursing staff. The beatings lessened somewhat and she eventually died of another stroke in her home. The decision to support her wish to remain in the community was made because we felt that she had the right and competence to decide to remain at home.

Another lady was 83. She was cared for by an alcoholic and brain-damaged daughter. The hospital said they could do nothing to prevent the daughter from taking her home. The police could do nothing because when they came both mother and daughter would deny the problems. She was beaten around the head and neglected and not cared for. At one point in time, the mother sat for 5 weeks in one chair until she became so deteriorated the daughter allowed her to be hospitalized. During that final rehospitalization, we did involve the hospital, the doctors, and probate court to obtain a guardian for her. Eventually, both mother and daughter were declared incompetent and placed in a nursing home where they remain today.

We have no adult protection law in the State of Ohio. We do have a domestic violence law, but it is ineffective in these cases because the injured or threatened person must ask for intervention, or at least be willing to sign papers acknowledging that he or she has been injured or threatened. Also, the domestic violence law only provides for prosecution of the offender and removal of the offender from the home. It provides for no services to the victim and does not cover neglect or exploitation. Of our sample that we talked with, only four did anything whatsoever to seek protection for themselves and only two were self-referred. Some denied or were resigned to the mistreatment, others were frightened or depressed or withdrawn. Some were too confused to make any statements at all. Also, the domestic violence law makes no provision for mandatory reporting, legal protection for the person who reports, or mandatory prompt investigation. Intervention must always be with client and care-giver's consent.

In another case, we had an elderly woman who was living with her son in this situation. The father had committed suicide when the son was 16. One son had joined the army but was discharged and diagnosed as schizophrenic. The other son had left town. The mother cared for the mentally ill son until she was 75, when she fractured her hip and he became care-giver for her. In this situation the son initially allowed us in the house. The house was disorderly, plumbing was broken and excrement was dumped in the yard. The son then refused to allow us in. His psychiatrist at the veterans' hospital said he was not interested in the home situation. Two months after we got her case, this lady died at her home. The son then cleaned up the house, sold it and moved away.

In another situation, we had an 86-year-old woman who was referred by her sister who reported she was bedridden, had bedsores, weighed only 80 pounds, and was left naked in bed all day. She had some money in the bank and owned her house. When we talked to the son she lived with, he denied everything. He said the sister was a liar, that he got his mother up every day, gave her wonderful care, fed her, and brushed her hair. Our legal consultant said we had no legal right to intervene, the police had no right to enter, and the only way to do anything was to get the sister to go to court. The sister was reluctant to do so. A month after referral, we heard that the lady had died.

Of the 39 cases included in our study, assistance was offered to all. In 28 percent of the cases, intervention was utilized and the person remained in the community. In 46 percent of the cases, the abused person was eventually placed in a nursing home because the problem could not be resolved in any other way, and no less restrictive alternatives were available. In 26 percent of the cases, we were able to do nothing because the caretakers or abused persons refused to allow us in and we had no legal or other recourse. In one case, legal action was threatened against the Chronic Illness Center.

To combat this problem, there needs to be Federal and State legislation and trained personnel in every State, available in every community, to combat and deal with abused adults as there is in existence to deal with abused children. Present Federal programs provide funding to State for adult protective services. We do get title XX moneys in the State of Ohio, but because there is no mandatory reporting, no protection of reporters and, no mandatory investigation, we are often able to do nothing.

We feel that Congress needs to make a clear statement that abuse, neglect, and exploitation of all adults is intolerable and also enact Federal legislation to promote State response to the problem. We feel there should be funding incentives to the States to enact carefully drawn mandatory abuse reporting laws, accompanied by provisions for legal intervention if necessary.

The Child Abuse Prevention and Treatment Act of 1974, as in 1978, could serve as a prototype. This law and the related Federal regulations insist that a State meet certain legislative requirements in order to be eligible for program funding. They include, along with other requirements:

(1) Mandatory reporting of suspected abuse.

(2) Immunity from suit by those persons who are required to make reports.

(3) A statewide system with the capability for immediate investigation and service provision.

(4) Law enforcement cooperation.

(5) Stringent rules around confidentiality.

In addition to these important elements contained in the child abuse law, I would like to add five additional elements:

(1) Provision of services based on the least restrictive alternative.

(2) Provision for court intervention if the care-giver's consent to investigation or service is refused, there is probable cause to suspect abuse, and the adult person consents.

(3) Provision for court intervention if the adult person refuses consent and it can be proven that he/she is incapable of giving informed consent.

(4) So far as possible, participation of the adult person in making the decision as to the action which should be taken to meet his/her needs.

(5) Protection of the person's right to refuse protective services if he/she is capable of informed refusal to consent.

Federal legislation, including provision for funding, will increase motivation of individual State to enact State legislation.

Senator PRYOR. We are beginning to run out of time. I am going to ask if you would submit your full prepared statement—a very fine statement, I might add—for the record. It is most informative and factual. We may want to ask you some questions about your statement.

Ms. LAU. Very well, I might add that I am pleased that today Congresswoman Mary Rose Oakar introduced her bill, Adult Abuse Prevention and Treatment Act, which addresses the points I have mentioned in my testimony. I hope that other Members of Congress will give it careful consideration and cosponsor the bill. The rapid passage of this Federal legislation will provide the necessary incentives to the States to enact their own legislation focusing on this critical problem.

[The prepared statement of Ms. Lau follows:]

PREPARED STATEMENT OF ELIZABETH LAU

Honorable Chairpersons and Members of the Senate and House Aging Committees; my name is Elizabeth Lau, I am a protective services worker and social work supervisor from the Chronic Illness Center in Cleveland, Ohio. Our agency has been providing protective services to the elderly for over 10 years as a part of the Cuyahoga County hospital system. We serve chronically ill and elderly persons living in their own homes, as an interdisciplinary agency providing assessment, counseling, planning, coordination, and various direct services. Ohio has no adult protection law, but we receive funding through the Ohio Department of Mental Health and Retardation, title XX and the Cuyahoga County Commissioners.

In the spring of 1978, the social work school at Case Western Reserve University planned a conference on the battered person and because I had worked with many cases of abused elderly, I decided to prepare a paper on the battered elderly. At that time, I learned that no research had focused on this problem, its frequency or its causes. A few newspaper articles had appeared around the country and the problem was briefly discussed in a report on domestic violence assembled by the State of Ohio Attorney General's office which was published in 1978. Following the Case Western Reserve University conference on the battered person, I did a study with Jordan Kosberg, associate professor at the social work school, entitled "Abuse of the Elderly by Informal Care Providers," which was presented at the Gerontological Society meeting in Dallas, Tex., November 20, 1978, and later published in Aging magazine, a HEW publication, in the fall of 1979.

This was a descriptive study in which workers at the Chronic Illness Center were asked to review all new cases of persons 60 or over assigned during a 1-year period, to identify cases showing evidence of physical, psychological or material abuse, or violation of rights. Our definitions also include severe neglect. This paper, in its entirety, will be presented for inclusion in your written record.

We found that 10 percent of our clients, age 60 or over, suffered some type of abuse, a total of 39 clients. Of these clients, 30 were women, 21 were widowed and 29 were white. Twelve lived alone, nine with a spouse and the rest with children, grandchildren or other relatives. The majority lived in private homes (29). Twenty-one lived in the city, 12 in boundary suburbs and six in outlying suburbs. It is clear that elder abuse is found in all geographic, racial and socioeconomic groups. Over three-quarters of these abused persons had at least one physical or mental impairment (51 percent problem in ambulation, 10 percent vision or hearing loss, 18 percent partially or totally incontinent, 41 percent confused).

Because of the method used in collecting data we feel that the incidence of abuse in our client population was probably underreported. We defined 13 types of abuse and 72 percent of our clients suffered from two to five types. Only 15 percent were abused in just one way (74 percent were physically abused or severely neglected, 51 percent psychologically, including verbal assaults, threats and isolation, 31 percent materially, including theft or misuse of money, belongings, or property, 18 percent had rights violated, usually being forced to move away from their homes to another residence or nursing home).

Abusers were usually the relatives upon whom abused persons were dependent for care and/or assistance. In many cases, the abusing persons had problems of their own, such as retardation, mental illness or alcoholism. Abuse is often the behavior which occurs under the stress of overwhelming, unrelieved, care responsibility following a long history of family problems, conflict, or family violence.

Mrs. F., 83, who had a stroke, was in a wheelchair, and had expressive aphasia, was beaten with a hairbrush by her care-giving sister, to punish her for incontinence and disobedience. This care-giver had also rescued her and nursed her back to health after years in a poor nursing home and had raised and harshly disciplined ten sons, many of who had been in juvenile court. Despite the beatings, Mrs. F. expressed a clear wish to stay at home where she was often with many family members. She did so, supported by social work, homeaide, medical and nursing staff; the beatings lessened somewhat and she eventually died from another stroke. The decision to support her wish to remain in the community was made because we felt that she had the right and competence to decide to remain at home.

Mrs. S., 83, was an even more difficult case. Mrs. S. lived with an alcoholic daughter, 56, who was originally referred to CIC after a long hospitalization for alcoholism with brain damage. Mother was afraid of her and asked us to close the case. A year later, mother was hospitalized and daughter demanded to bring her home even though daughter was a known brain-damaged alcoholic. The hospital stated they could not interfere. Mrs. S. was quickly rehospitalized and briefly placed in a nursing home. She was again brought home by daughter who had agreed to CIC services but still neglected, and physically and verbally attacked her. When the police came, both would deny the problems, relatives who observed the beating refused to testify for fear of being sued, the police were helpless, mother sat in one chair for five weeks before she became so deteriorated that the daughter allowed our nurse and worker to rehospitalize her. This time, we talked and wrote letters to the hospital, doctors and probate court and finally obtained a guardian for Mrs. S. The eventual outcome some two years later was that daughter was also declared incompetent, had a guardian appointed and mother and daughter are now living in the same nursing home and doing well.

Ohio has no adult protection law. We do have a domestic violence law but it is ineffective in these cases because the injured or threatened person must ask for intervention or at least be willing to sign papers acknowledging that he/she has been injured or threatened. Also, the domestic violence law only provides for prosecution of the offender and removal of the offender from the home. It provides for no services to the victim. Only 4 of our 39 clients did anything to seek protection and only 2 were self-referred. Others denied (13), were resigned to it (10), were frightened (6), depressed (4), or withdrawn (8). Some were too confused to make any statements at all. Also, the domestic violence law makes no provision for mandatory reporting, legal protection for caregivers or mandatory prompt investigation. Intervention must always be with client and care-giver's consent.

Mrs. P. and her husband had raised their two sons in isolation. They were never allowed out of the yard, were allowed no friends, and required to go to church daily. When their son, T.P. was 16, the father committed suicide in the house. His brother, when grown, left home, married and moved far away. T.P. joined the army but was quickly discharged as mentally ill, totally disabled, schizophrenic. His mother cared for him until he was 50; she was 75 when she had fractured her hip and he became care giver for her. He brought alcohol to her daily. The house was disorderly, plumbing was broken and excrement was dumped in the yard. Mrs. P. was dirty, malnourished and had no medical care. T.P. initially let our worker in, then refused. His psychiatrist at the Veterans' Hospital said he was not interested in the home situation. Two months after we got the case, Mrs. P. died at home. T. P. then cleaned up, repaired the house, sold it and moved away.

Mrs. B., 86, was referred by her sister who said Mrs. B. was bedridden, had bedsores, weighed only 80 pounds and was left naked in bed all day. Her mind was good and she had $3,000 in the bank and owned her house where she lived with her son. Sister said the son was waiting for her to die to get her money. Son said sister was lying, that he and his brother bathed mother daily, brushed her hair, got her up to eat good food at the table and they needed no help. Our legal consultant said we had no legal right to intervene, the police had no right to enter and the only way to do anything was to get the sister to go to court. She was reluctant to do so; a month after referral, we heard that Mrs. B. had died.

Of the 39 cases included in our study, assistance was offered to all. In 18 percent, intervention was utilized and the person remained in the community. In 46 percent of the cases, the abused person was eventually placed in a nursing home because the problem could not be resolved in any other way and no less restrictive alternatives were available. In 28 percent of the cases, we were able to do nothing because the caretakers or abused persons refused to allow us in and we had no legal or other recourse. In one case, legal action was threatened against the Chronic Illness Center.

To combat this problem, there needs to be Federal and State legislation and trained personnel in every State, available in every community, to combat and deal with abused adults, as there is in existence to deal with abused children. Present Federal programs provide funding to States for protective services under the Social Security Act title XX but mandatory reporting, investigation and emergency protective services are not included by law in Ohio. This leaves the protective service worker unable to investigate or intervene in cases of abuse or neglect where care giver or client refuses access. Congress should not only make a clear statement that abuse, neglect and exploitation of all adults is intolerable but also enact Federal legislation to promote State response to the problem. It can provide funding incentives to the States to enact carefully drawn mandatory abuse reporting laws, accompanied by provisions for legal intervention if necessary. Such legislation should support the States' interest in protecting adults at risk, balanced by the equally important right of these persons' right to privacy (and self-determination). These competing interests have been weighed carefully in several model statutes and in some existing legislation.[1] [2] [3]

The Child Abuse Prevention and Treatment Act of 1974, as amended in 1978 could serve as a prototype.[4] This law and the related Federal regulations [5] insist that a State meet certain legislative requirements in order to be eligible for program funding. They include, along with other requirements:

(1) Mandatory reporting of suspected abuse.
(2) Immunity from suit by those persons who are required to make reports.
(3) A statewide system with the capability for immediate investigation and service provision.
(4) Law enforcement cooperation.
(5) Stringent rules around confidentiality.

In addition to these important elements contained in the child abuse law, the following elements should be included:

(1) Provision of services based on the least restrictive alternative.
(2) Provision for court intervention if the care-giver's consent to investigation or service is refused, there is probable cause to suspect abuse, and the adult person consents.
(3) Provision for court intervention if the adult person refuses consent and it can be proven that he/she is incapable of giving informed consent.
(4) So far as possible, participation of the adult person in making the decision as to the action which should be taken to meet his/her needs.
(5) Protection of the person's right to refuse protective services if he/she is capable of informed refusal to consent.

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[1] Model Adult Protective Services Act, contained in Protective Services for the Elderly, a working paper prepared for the Special Committee on Aging, U.S. Senate, July 1977.

Proposed Legislation for the Commonwealth of Massachusetts, prepared by Legal Research and Services for the Elderly, 2 Park Square, Boston, Mass. 02116. (A summary of the legislation's contents are contained in "Elder Abuse: The Hidden Problem," a briefing by the Select Committee on Aging, U.S. House of Representatives, June 23, 1979, Boston, Mass.)

Block, Marilyn, and Sinnott, Jan D. (editors), "The Battered Elder Syndrome, An Exploratory Study," Center on Aging, University of Maryland, College Park, Md., November 1979 (suggested legislative wording contained in pp. 97-107).

[2] Eleven States have passed some form of reporting and protective service legislation: Virginia, Nebraska, Arkansas, Alabama, North Carolina, Florida, South Carolina, Connecticut, Oklahoma, Kentucky, Tennessee.

[3] "Proposals Relating to Congressional Action on Protective Services Legislation for the Elderly with Specific Reference to Issues of Their Abuse, Neglect and Exploitation," undated paper, 1980, Benjamin Rose Institute, Cleveland.

[4] 42 USC Sec. 5101 et seq.

[5] 45 CFR 1340 et seq.

Federal legislation, including provision for funding, will increase motivation of individual States to enact State legislation. Currently, only 11 States have adult or elderly protection laws and there is substantial variation among them. Enacting Federal legislation which states essential elements for inclusion in each State's law as a condition of eligibility for funding, will also effect some uniformity of abuse legislation among the States.

Included in the provision of the Child Abuse Act was a National Center on Child Abuse and Neglect. Such a center for adult abuse would serve as a clearinghouse for research and information as well as offering technical assistance and perhaps grant moneys to organizations in the field. Elder abuse and abuse of other adults has only begun to be studied and no substantial body of data or knowledge yet exists.

Only 11 States have adult or elder abuse legislation. Under the auspices of the Cleveland Federation for Community Planning, the Chronic Illness Center, and other public and private agencies,[6] are drafting legislation to be introduced in the Ohio Legislature at its next session. The draft will be based on existing statutes in other States, on model statutes, and on the opinions of authorities and researchers in the field of adult abuse. The proposed Ohio legislation will provide for the inclusion of all 10 essential elements mentioned previously. It is important that each State carefully design legislation appropriate to the standards and existing structures in that State.

Senator PRYOR. At this time I will call on the final witness on this particular panel before we begin our questions.

Mrs. Hill.

STATEMENT OF MARY HILL, ASSISTANT ADMINISTRATOR, CENTURY HOME, INC., BALTIMORE, MD.

Mrs. HILL. Mr. Chairman, Mr. Cochairman, distinguished members, I want to thank you for giving me a chance to bring to your attention some of the things that have happened and continues to happen to people who are very dear to me, the elderly, in Baltimore.

Our home is in the inner city. Our patients receive medical assistance. We do not have the criteria that they must be on medical assistance to be admitted.

Senator PRYOR. When you say medical assistance, are you talking about public assistance?

Mrs. HILL. Yes. We are located in an area that most of the people who are near this home have been indigent, or nearly indigent, their entire lives, so when I talk to you about the $25 social security supplementary income, this looks like a huge check to these people when they get it.

I would like to explain basically how this home operates. These people, if they have ever worked, have some form of social security or retirement, and this comes into the home or comes to the patient. The State of Maryland has a policy where so much is paid per diem for the patient to be cared for. What their social security check does not cover, the State reimburses the home for the amount that is charged per day, and that cost is decreed by the Maryland State Legislature.

Besides this, these patients receive at most a $25 supplementary income check. This is for the patient to have for their own personal income.

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[6] The Task Force includes representatives of the Federation for Community Planning, The Benjamin Rose Institute, Chronic Illness Center, the Legal Aid Society of Cleveland, Cuyahoga County Department of Public Welfare, Geauga County Department of Public Welfare, Nursing Home Ombudsmen Program, and a representative from the office of Congresswoman Mary Rose Oakar. Eventually the draft will be circulated to other interested organizations and to legislators for comments and revisions.

On admission to our home, the patient, if they are capable of making the decision, and a family member decide whether the patient will control their funds or whether this established family member will control that $25. That comes in the first of the month with the other checks. The patient signs it. The family can pick up that check from the office. Oftentimes, the family picks that check up. We have set a date of the 9th or the 10th of the month that they can have it, to make sure that the families do not come in and upset the patient because there has been a delay in the mail. They will pick up this $25 check and we never see the family again, and most times if we have a phone number, we cannot reach them until the 9th or the 10th of the next month.

I have a few cases that I would like to cite just to give you an idea of what really happens. We admitted a female diabetic patient from one of the acute care hospitals in Baltimore City. The Century Home, I might say, has a policy that a lot of nursing homes don't have. We know about the period of adjustment when you move the elderly from one institution to another. We go and visit the patient in the acute hospital before we admit them to our home.

In talking to the nurse on the floor the day that we decided to take this admission, she gave me some family background of how bad the condition of this patient was when she was admitted. She had been lying on newspaper and some of it was embedded in her body and they had to pick it out at this hospital. We took the patient with a rather extensive decubitus. We felt it started to heal and from looking at the chart, I felt we could handle this patient.

The patient and her husband were receiving social security. Her check was still going to her home. We repeatedly, as required by Maryland State law, called the home and asked the husband to turn in the check. He refused to do it. The first month he didn't bring it at all the second month he did. The third month he said, "I am coming to get the patient; you are feeding her, you are giving her a bed to sleep in. My wife that I have in the home"—and, remember, the patient in our home was his legal wife—"and I need that check."

He came to pick this lady up on a cold November morning by public transportation, with a dress, no underwear, no coat and no stockings. I refused to let him take her out of the building. I don't know, maybe he could have sued me, but I would not let her go out. I got our medical director to write an order that she was being discharged against medical advice, but he would not allow her to leave the home until she was properly attired.

I had another woman, who the daughter and husband both were gainfully employed, who were using the mother's social security check to cover their car payment. When it was explained by the DSS office of Baltimore that they must turn over the social security check to the home for them to be able to pay the remainder of the mother's care they took her home. Now we can only assume that this lady was left all day and she was a diabetic. I often think about this patient and wonder if she is still alive.

I have one other that is especially touching to me because I was a papa's girl and she happened to bring her father to the home to be admitted. This old gentleman always wears a shirt and tie and she brought him in in mid-July. She brought a suit with him and it was a very thin seersucker suit.

Our home had chartered a bus to take all of the patients that were able to go on a picnic at a State park. This happened in September and it was a rather chilly morning. My director of nurses came to me and she said, "Mary, I believe that this patient should have a sweater." We had some coat sweaters in stock that were purchased for our patients' needs. You must remember, with these 82 patients, I have only 18 families who pick up social security checks, so we have to furnish a lot of needs for the family. So we furnished this man with a coat sweater from our stock at the cost of about $7.

When the daughter came in to pick up the check she demanded the $7. She said she could have—and this patient, I might add, was perfectly capable of telling me he wanted to go to the picnic. I would like to add we tried to contact the daughter by phone to get her permission. We did not reach her. She demanded the money for the sweater because she said that they could not afford to pay for a sweater for him and he did not need it. The owner of the home reimbursed her for the sweater. Yesterday, I happened to meet the patient on the stairway and he was still wearing the sweater.

Of the 82 patients I have, 18 family members pick up checks. There are only three who will tell me anything or show any visible signs of what they do with that money when they walk out of the building.

Thank you.

Senator PRYOR. Thank you, Mrs. Hill.

I think Congressman Pepper is going to lead off with the questions.

Representative PEPPER. I would like, before I ask any questions, to state that a very distinguished member of this committee, Mrs. Byron from Maryland, was not able to be here for this hearing today, but she wanted it to be known and made part of the record that she has consulted with Mrs. Hill regarding this problem and regrets very much that she is unable to be here today to hear the testimony from Mrs. Hill. I ask that Representative Byron's letter be inserted at this point in the record.

[The letter follows:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C.

Hon. CLAUDE PEPPER,
Chairman, House Select Committee on Aging,
Washington, D.C.

DEAR CHAIRMAN PEPPER: The Military Compensation Subcommittee of the House Armed Services Committee, of which I am a member, will be drafting an important piece of legislation on the morning of June 11, 1980. As a result, I will not have the opportunity to personally introduce Mrs. Mary Hill to the members of the House and Senate Committees on Aging which will be conducting a joint hearing on "elder abuse."

Over recent months, I have had the chance to correspond and meet with Mrs. Hill to discuss her concerns about the problems of senior citizens, particularly those in nursing homes such as the Century Home for which Mrs. Hill is the assistant administrator. I am sure that the members of the committee will find Mrs. Hill's comments and insights on this subject to be very enlightening. I am equally convinced that her observations on the financial abuse of the elderly will be of critical concern to the members. It is my hope that you will indicate to Mrs. Hill my personal regrets that I could not be present and give her the same special attention which you always give to those who seek to constructively address the many unique problems of the elderly.

With very best regards, I am

Sincerely,

BEVERLY B. BYRON.

Representative **Pepper**. First, let me ask you all collectively, do you find that the abuse of the elderly of which we are speaking is caused in nursing homes as well as in private homes?

Mr. Regan.

Professor **Regan**. Congressman, I think there is little doubt that it is present. Certainly, the hearings and findings over many years of both the Senate and House committees looking into long-term care, I think, would substantiate the conclusion that there is a great deal of abuse in the nursing homes. Certainly, the testimony here today indicates a similar pattern of abuse in the home as well.

One area which we have not touched on, however, which ought to be mentioned as well, and it typically occurs in a larger protective services context, is self-neglect. Perhaps that is one of the most difficult problems of all for an agency person or a caseworker to deal with. That aspect of abuse ought to be mentioned to complete the picture that is being presented today.

Representative **Pepper**. Thank you.

Mr. Tilley.

Mr. **Tilley**. I concur with Mr. Regan.

Senator **Pryor**. Dr. Mahoney.

Dr. **Mahoney**. Mr. Chairman, I think I would agree that it does cut across both lines, but our evidence seems to suggest that there was perhaps more of this within the home. We have had the most recent case in Massachusetts within the past 4 days. We had a case of an elderly woman, who is emotionally disturbed, confined to her bed and discovered by a visiting home nurse. This woman was unclad, hungry, and incontinent. The room was padlocked and very poorly illuminated. No one had attempted to clean her for perhaps a week.

The husband was well aware of the condition. The son was also well aware of the condition. We had the local chief of police notified. It was found that the victim had been molested and was suffering from malnutrition. Fortunately, she is now in institutional care and she is going to be all right. Steps are going to be taken through the attorney general's office to prosecute. I think we have more of that within the home, and this earlier study that the department commissioned bore that out. Usually, the abuser was a member of the abused's family.

Representative **Pepper**. Ms. Lau.

Ms. **Lau**. I would guess that there probably is as much abuse in institutions as there is in the community. I tend to think that the abuse of some persons in the community may be more severe in terms of severe neglect, severe isolation, people being shut up in dark rooms and chained to beds, and that sort of thing, in the community. I think the issue of self-neglect is a very difficult one, especially in the area of determining the person's capability or competence to make decisions, to refuse care or to continue living in what we may more or less determine to be a substandard living situation. I think people when adjudged to be competent do have choices and the right to maintain their independence in that kind of situation.

Representative **Pepper**. Mrs. Hill.

Mrs. **Hill**. I feel that the licensing laws of the States prevent any great amount of abuse in nursing homes. We are constantly surveyed, we are constantly monitored. In our nursing home, I have had one incident of an employee abusing a patient. I immediately fired him.

The firing stood up, the union didn't interfere. They made a feeble effort of protecting the man, but the decision stood.

I have never had a repeat of it since. I went to this particular home in October 1978, and this happened about 1 week before Christmas and from then on I have had nothing. I find the employees care more. The abuse comes to a large extent by the family neglecting them by not coming in to see them, or in many cases of taking their money and not really giving them anything in return, or not accounting for it. My feeling is if I take a $25 check that belongs to my mother or any relative, I should have to account for every penny I spend. I should have to use it on this relative. I should be able to show receipts for what I did with it. I should be making arrangements for death, and a lot of people have a problem in facing this, but when we get old, eventually we are going to die.

Representative PEPPER. That check was not intended for the family.

Mrs. HILL. That is right.

Representative PEPPER. That $25 check was intended for the personal use of that individual. It is like being in the hospital, you need a little change for a few things, and that was intended for the personal use. I wish there was some way under the law where we could keep anyone else from getting it.

I reckon the individual gives it to them technically, they hound them until they make them give it to them. There is not any way that you know of that we can keep them from getting that check, is there?

Mrs. HILL. Mr. Chairman, I have found that they come in with the pretense, I will take momma's check and I will go buy her a gown, or momma is in now and she won't be able to get out, so I will take care of her needs. In our particular home some of our nursing assistants even take the patient's laundry home and do it for them themselves rather than for it to go to a commercial laundry.

But oftentimes they sign this statment. I have a copy of our admission agreement that I will submit, and what this is basically for is for the person to say he or she will be responsible for any insurance policy that is left on the patient, to do their laundry, to pick up the little niceties that they might like. We furnish all of their toiletries that they need, but there occasionally is something, as you say, that they would like and they would like to have some change to get it. We are very close to Lexington Market. Maybe they would like something from the Yogurt Tree, or something of that sort.

Representative PEPPER. That is what it was intended for. Is there some way we could look into that to see whether or not it might be made an offense if anybody would take that check? I know we have had hearings where there were cases where we found sometimes that the nursing homes would induce the patient to give them the check, let them keep it, let them keep the money and they can't get the money back. They could budget the money.

Mrs. HILL. I think that is covered in Maryland by an accounting system that we have. If we have a patient who is not able to control $25 at one time at his bedside, we have an account for them, and activities, or a social worker will issue them money and the patient signs a receipt. This account is audited four times a year for any patient who requests that the home take care of their money. They still have that money, it is technically in their possession, because they can get it within minutes when they ask for it.

Representative PEPPER. Let me ask each one of you for a quick summary. How do you think the Federal Government can best be helpful in this whole area that we have been discussing here today?

We will start with you again, Dean.

Professor REGAN. Title XX of the Social Security Act and title III of the Older Americans Act, whatever the vehicle, should be amended to promote the development of protective services legislation in the States through incentives of a financial nature and through prioritization of this particular service as compared with others authorized in those sections.

Second, along with the carrot there also ought to be some protective legislation or protective requirements at the Federal level as well, as suggested before. It seems to me that in the name of intervention much abuse can also occur from a different sector, the intervenor himself, and therefore while promoting protective services, Government must be very concerned about controlling the intervenors so that they respect the civil rights of those whom they are helping. Therefore, minimum standards protecting the civil and constitutional rights of clients ought to accompany the extension of aid to those States that cooperate in these programs so that we have a joint effort of both help as well as control provided through this legislation.

Representative PEPPER. Thank you.

Mr. Tilley.

Mr. TILLEY. I agree. Prioritization in money, the Older Americans Act right now says that State aging networks will function as advocates for older Americans. Who more needs an advocate than an abused adult?

Representative PEPPER. Excuse me. This area, it seems to me, is also well calculated of need, some assistance from the ACTION corps where elderly people might help look up and try to find out about other elderly people who might need help. Do you think there might be a possibility of help in that area?

Dr. Mahoney, you gave your summary.

Dr. MAHONEY. Well, the last point you touched on, Mr. Chairman, is one that is near and dear to my heart. We have an "Elder Service Corps," based on the theory that peer relationships are more effective and more viable than if you send young people in to deal with elders.

The problem with this whole question of elder abuse depends on funding. We have a budget in Massachusetts that is on the order of $78 million for Elder Affairs. Sixty million dollars of that is provided by the State. We spend more per capita than any State in the Union on its elderly. Now this means we need Federal help.

I am here often enough to know that the well is drying up, but this is an area, it seems to me, in which the Federal Government has the responsibility to provide the funding. I indicated earlier that just to begin the kind of protective services that we think we need in Massachusetts would need to start up on the order of $3 million. We don't have it. We could do so much more if we could get funded. I agree with my colleagues here that a cooperative effort is called for, but the majority of the funding has got to come from here, because the States don't have it.

Representative **Pepper**. Thank you.

Ms. Lau.

Ms. **Lau**. Mr. Chairman, I feel there are a number of ways that the Federal Government could be helpful. First of all, with Federal legislation, such as the bill introduced today by Congresswoman Oakar, which would provide the carrot and the States would follow with their own legislation, but also with some type of supports which would reduce some of the stress on the care givers and provide services to elderly people in the community. In Ohio, at least, when an elderly person moves in with their family, if they are on SSI, that SSI is reduced. They become more of a burden in the family home then because their income is reduced.

If there were financial incentives, perhaps better care could be given to persons and the stress caused might not be so great. There is also a need for respite care which they do have in Great Britain, where a person goes to a nursing home for 1 or 2 weeks just to give the family some relief once a year.

Also, there should be alternatives such as family care or group homes, or provision for more services within the home—home aide service, meals on wheels, any kind of service which will go to the elderly person if they are in a relative's home. In general, an elderly person living in the home of a relative will receive less services, or be eligible for less, than an elderly person living in the community.

Most people do not want to go to nursing homes. We were talking about removing a person from the home for their own protection. There are many people who will choose to stay in an abuse situation rather than go into a nursing home where they will become very depersonalized.

Thank you.

Representative **Pepper**. Thank you.

Mrs. Hill.

Mrs. **Hill**. I, too, feel that Federal help is necessary, but I think the legislation should make for accountability. Accountability is the whole thing. They can sign any agreement and not meet the obligation. Possibly a protective service of some kind, to make sure they will be accountable for any obligation they make. There has to be some agency or group that will come back and make them accountable. Any nursing home that cares for the aged, through licensing or other means, are held accountable for everything they do. Yet, the patient is not protected from his family, who will take from them and not help take care of them. If we cannot protect our aged in any other way, then let us make the family accountable for what they do.

Representative **Pepper**. I must say by way of conclusion that this morning we have heard a new and tragic chapter in the long and sordid history of man's inhumanity to man.

Senator Pryor.

Senator **Pryor**. I would like to ask, if I might, of Bryan Tilley, how many staff members do you have in the Protective Services Division in Arkansas?

Mr. **Tilley**. We have only four.

Senator **Pryor**. To basically serve 2 million people you have four staff members?

Mr. **Tilley**. Yes, sir,.

Senator Pryor. Do you feel that the State should furnish the inspection end of the adult protective services or should the Federal Government furnish that inspection phase of this concern?

Mr. Tilley. I believe that the investigatory provisions and indeed the whole mechanical process ought to be a State government function. It is going to vary from us in Arkansas to maybe people in Massachusetts and New York.

Senator Pryor. Ms. Lau, I would like to ask this question and it sort of relates to the question I asked Mr. Tilley. How do most of these abuses get attention? How do they surface?

Ms. Lau. Well, we get most of our cases by referral from hospitals, visiting nurse associations, golden age centers, a number of community facilities. Occasionally we will get one from a relative or neighbor where the person is living at risk. Very seldom do we get cases referred by the person who is abused.

Senator Pryor. If there is an elderly person who is undergoing some degree of abuse and the children of that person, assuming they are adults and say in their 40's or 50's or whatever, say that they do not want any service whatsoever rendered to their parent, how long does it take one to possibly get legal relief or for you to go in and give service, or for the proper agencies to give service to that individual, protection to that individual or the services that that individual needs? How long does this legal fight take?

Ms. Lau. In the State of Ohio, there is no way to give aid if the relative refuses our intervention into the situation, especially if that elderly person lives in the adult child's home. We try very hard to work with these adult children, as if they are also our clients, as if they are voluntary clients to extend help, assistance, and support to them, to offer them sympathy and understanding of how difficult it is for them to care for the elderly.

Senator Pryor. So that elderly person could acutally become or could be a captive, or let us use the word hostage, and still the proper governmental agencies, protective agencies, could not actually enter in or intercede, I should say, and help that person?

Ms. Lau. Not unless some other person had actually witnessed the abuse and is willing to go to court. The situation that I mentioned, the sister was very fearful. She had witnessed the situation that this one woman was living in, but she was afraid to do anything. People are afraid of getting sued and threatened and may be injured themselves.

Senator Pryor. Dean Regan, we may have other questions. Briefly what do you think the major components should be in an adult protective services law that is drafted in the State legislatures? I am not talking about what the Congress ought to be doing. I am talking about what the States ought to be doing and what the major components of that legislation should be.

Professor Regan. The first would be provision for an updating of the States' guardianship law which takes care of long-term intervention in the lives of those who are typically the self-neglectful type.

Second, there ought to be a provision for short-term medically oriented intervention through quick proceedings in a court to authorize temporary guardians so that care can be provided.

Third, there ought to be a provision for authorization for public and private social services agencies, not only to initiate guardianship proceedings should these become necessary, but also to themselves serve as guardians, accompanied however, by appropriate safeguards to protect the client.

Senator **Pryor.** The American Bar Association that you have been associated with, have they come forward with a model State legislative proposal in that area?

Professor **Regan.** The American Bar Association has not done so.

Senator **Pryor.** Would it be appropriate for the American Bar Association to develop such legislation?

Professor **Regan.** Various committees in the ABA have been talking about it and the commission itself has been looking into it. Of course, the working paper of the Senate committee has a proposal in it.

Senator **Pryor.** I am switching around quite a bit, but I have a vote and I have to run over to the Senate side.

Now I would like to ask this question of Mrs. Hill, because she has had a great deal of personal, everyday experience with these elderly citizens here. I would like to ask of the cases you see, who are the most likely to become abusive toward a parent and what might their characteristics or circumstances be? What causes that individual to become abusive of a parent or of an elderly citizen?

Mrs. **Hill.** Maybe, in the state of economy that we have today, it may be just pure, absolute frustration, because there is not enough money to do the things they want to do.

Senator **Pryor.** In child abuse there is a direct association between abuse of the child and unemployment rates as I understand it and as the studies demonstrate. Would that same direct correlation apply with our unemployment situation?

Mrs. **Hill.** I believe that it will. I know that in several of the cases that are involved with these checks it is people that you see standing on the street corner when you leave the home, that you know they cannot possibly be employed because you see them so many times of the day. As I said earlier, that $25 check is like a very large amount to them.

Senator **Pryor.** So the economic pressures——

Mrs. **Hill.** That is one of the reasons. Then maybe just complete frustration about everything. Mom is not the way she used to be, Pop is not the way he used to be, and I cannot cope with this. I do not know what to do with an incompetent mother and I don't want my aunt or my brother saying, well, you should never have put him in there, so I will make the effort of saying I will be responsible and I will go but then the guilt of having done it and all of it together. It is just a combination of not really knowing what they can do. It is a lot of things, but I really think the one pitiful thing that really takes it over the top is economics.

Senator **Pryor.** Mrs. Hill, one of the problems that both Senator Pepper and I have met on our Senate and House Committees on Aging and in the Congress is we want to help, yet we don't want the Federal Government to step in and become the big brother, so to speak, and to intrude or to intervene unnecessarily in families and in the lives of people. We are trying to find that proper balance, we are trying to find that proper entree when it is necessary, when there is abuse. We are trying to find the proper avenue and the proper resources to call forth to utilize in this whole complex area. It is an area

Senator Pepper—I always call him Senator Pepper. He was, of course a very distinguished U.S. Senator at one time and he came back to the House of Representatives. He will always be a distinguished Senator and a Congressman to me.

As I said, we are trying to really shed some light on this subject. It is an area that you and all of the members of the panel have done so well in sharing with us your own personal experiences. For my sake I would like to say thank you very, very sincerely.

Possibly other members of the committee would like to comment or ask questions.

Representative **Pepper**. Miss Oakar.

Representative **Oakar**. Thank you very much, Senator Pryor and Senator Pepper, again for conducting this hearing.

I would like to make a couple quick points. I think it is very, very important to know that when we are talking about elderly abuse we are talking about adult abuse but that is not the only definition of adult abuse that we have. Many mentally and physically handicapped people who are over the age of 18 are abused. It is too bad in a way that under the auspices of the Aging Committee we cannot go into other kinds of cases, but we have numerous other cases. We are scratching the surface, really, in dealing with the elderly and it is a good start and in the right direction.

One point that I would like to make, it has been mentioned by Dean Regan, and I thought your testimony particularly about guardianship was especially invaluable, but I would like to mention a few reasons why title XX may not be the answer to amending title XX. First of all, title XX is a title that everyone is just trying to get their hands on that money, there is not enough to go around.

Second, title XX addresses itself primarily to the poor. We have heard from Mrs. Lau in my own city of Cleveland. We are delighted to have the Senator so ably represented here. We have heard that this cuts across. We heard from the witnesses today it cuts across economic lines, not just talking about the poor. We are talking about people who are from a middle-class background also who have been exploited and abused, and so on. It would be a real difficulty, it would seem to me, to change the whole nature of title XX, and that is why I feel that this subject of adult abuse deserves its own title, that it deserves to be looked at as standing on its own feet.

Those are just the two points that I want to make.

I was very happy that Mr. Mahoney mentioned that the abuser needs help also, not just the abused. When we see the battered women, for example, we know that that husband needs some help and that possibly there is some hope for the marriage if they can both get the problem worked out, and so forth. So all these kinds of things, it seems to me, relate to and focus on the need for a comprehensive kind of approach that would involve the whole topic of adult abuse.

I wanted to extend the invitation to all of you to take the legislation introduced today and give us your insights and input with respect to it. We really desire to have your expert response to it so that if it needs to be changed around somewhat we can do that also.

Thank you very much, Senator.

Representative **Pepper**. Thank you, Miss Oaker.

Mr. Atkinson.

Representative **Atkinson**. Thank you, Mr. Chairman.

This question may have been covered already. Calling on my experience as a county commissioner before I came to the Congress, we had a geriatric center with a waiting list of 250 people, While they were waiting to get in there, some would go to nursing homes. I am just wondering how the lack of bed-care facilities, long-term care facilities, or any institutional facility contributes to abuse. There is no excuse for abuse, we all know that. But people would call up and say they don't have the special skills to care for their mother or father, they are deteriorating. So they call these facilities to get information or to obtain this kind of care. They wait a year, 2 years. By that time, they become so frustrated that it just changes their whole mental attitude and then they become abusive in certain ways. How much does the lack of bed care contribute to the whole overall problem?

Mr. **Tilley**. I would respond by saying in Arkansas, at least, lack of institutional beds is not the problem. The problem very often is the rugged individual—he has outlived his peer group, he has no family, he wants to maintain his independence, but he slowly and gradually loses that ability to take care of himself at home, not that there are not facilities there to take care of the person.

Representative **Atkinson**. Of course, there are all kinds of abuse. For example, in some nursing homes, poor diet is a form of abuse. Fire hazards are a potential abuse. The fact that there are not enough proper facilities is another abuse. Many citizens request that we close down poor nursing homes. Then what do you do? If you succeed in in closing them down, where do the people go from there?

Mr. **Tilley**. Our State nursing home regulatory agency has been exploring several different ways to sanction institutions who don't do right, if you will, and they are having a mixed degree of success with fines. They are trying a new system now of preventing new admissions to the facility that is not up to snuff. Obviously, the unlicensing and the closing of nursing homes for other institutions would be the final step.

Representative **Atkinson**. The final step?

Mr. **Tilley**. Yes, would be the most extreme action you could take.

Representative **Atkinson**. I speak to the frustration experienced by people. I know personally where a person tried for years to get their mother into a nursing home. The date of the application was the fact, but the frustration came when the person just called up on the phone after waiting maybe a year to get in and said, "My mother is going to be at the corner of 7th and Main, you better come and get her." And you go to the corner of 7th and Main and the poor soul is standing there. That is how frustrated that particular person had become.

In other instances, where again the self-neglect at home, the foster child trying to take care of a mother who is a double amputee, doing the bathing, doing the cooking. With a young person you can see how this would build in that person's mind to finally be abusive to the person she is trying to care for. Again in that instance it is because that person could not get into an institution.

My final question concerns the move toward normalization, get the institutionalized back home. Again, I am just curious as to what you have experienced as to forcing that person back either by the third party payer or by the administration of the hospital to free up a bed?

Mr. TILLEY. Absolutely. Deinstitutionalization is one of our foremost goals. We have taken long-term protective custody of individuals by court order We review those cases periodically. We are always wanting to move them from an institutional setting either back to their home or supportive services or to some other environment which is maybe quasi-institutional in nature.

Representative ATKINSON. Thank you.

Senator PRYOR. Mr. Regan, Mr. Tilley, Mr. Mahoney, Ms. Lau, and Mrs. Hill, we are very, very grateful to you for being with us today and for the valuable assistance you have given us. We hope that we can make your help meaningful to many people in this country. Thank you very much.

This concludes the hearing.

[Whereupon, at 1:55 p.m., the joint committees adjourned.]

APPENDIXES

Appendix 1

MATERIAL RELATED TO HEARING

ITEM 1. LETTER AND ENCLOSURE FROM WILLIAM A. FRYE, JR., SOCIAL AND REHABILITATIVE COUNSELOR, FLORIDA DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES, JACKSONVILLE, FLA., TO CATHY GARDNER, STAFF MEMBER, HOUSE SELECT COMMITTEE ON AGING, DATED MAY 19, 1980

DEAR MS. GARDNER: This will acknowledge our telephone conversation regarding abuse of the elderly. I was able to obtain the following information for you regarding abuse in Duval County.

Enclosed in the packet are four case examples[1] and a breakdown of statistics in Duval County. The case records are confidential, therefore it is necessary to delete the names of the clients. The cases are varied to show the types of abuse against the elderly.

I am glad that abuse against the elderly is recognized. The interest shown by the subcommittee will make the public more aware of abuse against the elderly. The major problem of those involved in abuse is the fact that the public is not aware enough to report such incidents. Until the reporting becomes more substantial it will be difficult to establish preventive measures.

As a worker in this field I am constantly made aware of individuals who have never been aware that abuse of the elderly exist.

It is hoped that the subcommittee will establish public awareness of this problem and help set up preventive measures. If I can be of further assistance please do not hesitate to call me at my office, 904-354-3961, ext. 2274.

Sincerely,

WILLIAM A. FRYE, Jr.

Enclosure:

ADULT ABUSE CASES IN THE LAST 6 MONTHS

November 1979 through April 1980: 73 cases of reported abuse, 49 cases involved the elderly.

Cases involving the elderly, broken down by months: November, five cases; three abuses, one exploitation, one neglect. December, eight cases; two neglect, six physical abuse. January, eight cases; two abuses, five exploitation, one neglect. February, four cases; three abuses, one exploitation. March, eight cases; three abuses, two neglect, three exploitation. April, 16 cases; seven abuses, eight exploitation, one neglect.

Broken down as to caretaker, relative, or acquaintance: November, five relatives; December, six relatives, two caretakers; January, four relatives, three acquaintances, one unknown; February, four relatives; March, five relatives, two caretakers, one acquaintances; April, 12 relatives, three caretakers, one acquaintance.

Whether or not substantiated or strongly suspected: November, three not substantiated, one probable but denies assistance, one substantiated; December, two not substantiated, two substantiated but declined help, four strongly suspected; January, two not substantiated, two substantiated but declines help, four strongly suspected; February, three not substantiated, one appeared likely but no conclusive evidence; March, six not substantiated, two substantiated but declined help; April, 10 not substantiated, two substantiated, one substantiated and being further assessed; three still open cases.

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[1] Retained in committee files.

ITEM 2. SUMMARY OF ADULT ABUSE PREVENTION AND TREATMENT ACT, SUBMITTED BY CONGRESSWOMAN MARY ROSE OAKAR [1]

Will create a National Center on Adult Abuse (under the Secretary of Health and Human Services).

Will provide money to States for adult abuse prevention and treatment programs if the States meet the following criteria:

1. Have in effect an adult abuse, neglect, and exploitation law which provides immunity for persons reporting instances of adult abuse, neglect, and exploitation
2. Provide for the reporting of known and suspected instances of abuse, neglect, and exploitation
3. Provide that upon receipt of such a report an investigation will be initiated and steps taken to protect the abused, neglected, or exploited adult
4. Have in effect administrative procedures, trained personnel, institutional, and other facilities, and multidisciplinary programs to deal effectively with the special problems of adult abuse, neglect, and exploitation
5. Provide for the confidentiality of records
6. Provide for the cooperation of law enforcement officials, courts, and appropriate agencies providing human services, with respect to special problems of adult abuse, neglect, and exploitation
7. Provide that the abused, neglected, or exploited adult participate in decisions regarding his/her welfare
8. Provide that the least restrictive alternatives are made available to the abused, neglected, or exploited adult
9. Provide for the dissemination of information about programs and problems of adult abuse, neglect, and exploitation

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[1] See statement, page 11.

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96TH CONGRESS
2D SESSION

H. R. 7551

To provide financial assistance for programs for the prevention, identification, and treatment of adult abuse, neglect, and exploitation, to establish a National Center on Adult Abuse, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 11, 1980

Ms. OAKAR (for herself, Mr. PEPPER, and Mr. RATCHFORD) introduced the following bill; which was referred jointly to the Committees on Interstate and Foreign Commerce and Education and Labor

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A BILL

To provide financial assistance for programs for the prevention, identification, and treatment of adult abuse, neglect, and exploitation, to establish a National Center on Adult Abuse, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Prevention, Identification, and Treatment of Adult Abuse Act of 1980".

NATIONAL CENTER ON ADULT ABUSE

SEC. 2. (a) The Secretary of Health and Human Services (hereinafter referred to in this Act as "Secretary") shall establish an office to be known as the National Center on Adult Abuse (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall—

(1) compile, publish, and disseminate a summary annually of recently conducted research on adult abuse, neglect, and exploitation;

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification, and treatment of adult abuse, neglect, and exploitation;

(3) compile, publish, and disseminate training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of adult abuse, neglect, and exploitation;

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing, and carrying out programs and activities relating to the special problems of adult abuse, neglect, and exploitation;

(5) conduct research into the causes of adult abuse, neglect, and exploitation, and into the prevention, identification, and treatment thereof; and

(6) make a complete study and investigation of the national incidence of adult abuse, neglect, and exploitation, including a determination of the extent to which incidents of adult abuse, neglect, and exploitation are increasing in number or severity.

The Secretary shall establish research priorities for making grants or contracts under paragraph (5) of this subsection and, not less than sixty days before establishing such priorities, shall publish in the Federal Register for public comment a statement of such proposed priorities.

(c) The Secretary may carry out functions under subsection (b) of this section either directly or by way of grant or contract. The Secretary shall promulgate regulations setting forth criteria for programs receiving funding under this subsection, and shall review programs funded under this subsection to determine whether such programs comply with such criteria. The Secretary shall, within 30 days after any determination by the Secretary that a program fails to comply with such criteria, terminate funding for such program.

(d) The Secretary shall make available to the Center such staff and resources as are necessary for the Center to carry out effectively its functions under this Act.

DEFINITIONS

SEC. 3. For purposes of this Act—

(1) the term "abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm or pain or mental anguish; or the willful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish, or mental illness;

(2) the term "adult" means any person who has attained the age of eighteen years (for the purposes of this Act, special focus will be given to persons who have attained the age of sixty years, mentally or physically handicapped persons, and women);

(3) the term "caretaker" means an individual who has the responsibility for the care of an adult either voluntarily, by contract, receipt of payment for care as a result of family relationship, or by order of a court of competent jurisdiction;

(4) the term "exploitation" means the illegal or improper act or process of a caretaker using the resources of an adult for monetary or personal benefit, profit, or gain;

(5) the term "neglect" means the failure to provide for oneself the goods or services which are necessary to avoid physical harm, mental anguish or mental

illness or the failure of a caretaker to provide such goods or services; and

(6) the term "physical harm" means bodily pain, injury, impairment, or disease.

DEMONSTRATION PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit organizations (or combinations thereof) for demonstration programs and projects designed to prevent, identify, and treat adult abuse, neglect, and exploitation. Grants or contracts under this subsection may be—

(1) for the development and establishment of training programs for professional and paraprofessional personnel, in the fields of health, law, gerontology, social work, and other relevant fields, who are engaged in, or intend to work in, the field of prevention, identification, and treatment of adult abuse, neglect, and exploitation;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the special problems of adult abuse, neglect, and exploitation cases, to provide a broad range of services related to adult abuse, neglect, and exploitation, including direct support and supervision of sheltered housing programs,

as well as providing advice and consultation to individuals, agencies, and organizations which request such services; and

(3) for furnishing services of teams of professional and paraprofessional personnel who are trained in the special problems of adult abuse, neglect, and exploitation cases, on a consulting basis, to small communities where such services are not available.

(b)(1) The Secretary, through the Center, is authorized to make grants to the States for the purpose of assisting the States in developing, strengthening, and carrying out adult abuse, neglect, and exploitation prevention and treatment programs.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State adult abuse, neglect, and exploitation law which shall include provisions for immunity for persons reporting instances of adult abuse, neglect, and exploitation, from prosecution arising out of such reporting, under any State or local law;

(B) provide for the reporting of known and suspected instances of adult abuse, neglect, and exploitation;

(C) provide that upon receipt of a report of known or suspected instances of adult abuse, neglect, or exploitation an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse, neglect, or exploitation, steps shall be taken to protect the health and welfare of the abused, neglected, or exploited adult;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of adult abuse, neglect, and exploitation laws and with the reporting of suspected instances of adult abuse, neglect, and exploitation, such administrative procedures, such personnel trained in the special problems of adult abuse, neglect, and exploitation prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with adult abuse, neglect, and exploitation cases in the State;

(E) provide for methods to preserve the confidentiality of records in order to protect the rights of the adult;

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and State agencies providing human services with respect to special problems of adult abuse, neglect, and exploitation;

(G) provide that the adult participate in decisions regarding his or her own welfare, and provide that the least restrictive alternatives are available to the adult who is abused, neglected, or exploited;

(H) provide that the aggregate of support for programs or projects, related to adult abuse, neglect, and exploitation, assisted by State funds shall not be reduced below the level provided during the twelve months preceding the date of the enactment of this Act, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects; and

(I) provide for dissemination of information to the general public with respect to the problems of adult abuse, neglect, and exploitation, and the facilities and with respect to prevention and treatment methods available to combat instances of adult abuse, neglect, and exploitation.

(c) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(d) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.

AUTHORIZATION

SEC. 5. There are hereby authorized to be appropriated such funds as may be necessary to carry out the purposes of this Act.

ITEM 3. ELDER ABUSE: AN OVERVIEW[1]

I. Nature of the Abuse

LACK OF INFORMATION

There are no statistics to document the scope of parental abuse by adult children, however, findings of a recent report conducted by the University of Maryland tend to suggest that elder abuse occurs less frequently than spouse abuse but as frequently as child abuse (600,000 cases a year on the average). After completing a 1979 study on elder abuse, Dr. Richard Douglas with the University of Michigan Institute on Gerontology concluded that maltreatment of the elderly is a real and complex problem about which too little is known and too little is being done.

MOST ABUSE IS DONE BY RELATIVES

Abusers are most often relatives of the abused. (Block, Marilyn R. and Sinnot, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979.)

MOST VICTIMS ARE WOMEN

In general, the abused elder appears to be severely disabled, older than average (75+), middle-class woman who is psychologically abused by her own relatives in spite of attempts to end the abuse by seeking help through normal channels. Anecdotal accounts suggest that the abused felt trapped in their situation. (Block, Marilyn R., "The Battered Elder," page 80.)

ELDER ABUSE: A RECURRING EVENT

A study undertaken in Massachusetts by Legal Research and Services for the Elderly found that elder abuse is a recurring event—70 percent of the surveys returned to those conducting the study indicated that abuse occurred more than twice. Further, 40 percent of the victims often received visible injuries. (Berman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, June 1, 1979.)

ELDER ABUSE LIKELY TO INCREASE

Situations where an older person is abused by family members are likely to increase as greater numbers of parents age and require care from their children. Decreasing fertility and mortality rates mean that there will be more older persons and fewer children available as possible caretakers. The adult child may be faced with as many as two sets of grandparents to care for, as well as aging parents. Further, increased divorce rates increase the likelihood that the caregiver will be providing the care without the financial or other assistance of a spouse. (Block, Marilyn R., "The Battered Elder," page 93.)

THREE ASPECTS OF ABUSE/NEGLECT: PHYSICAL, PSYCHOLOGICAL, AND FINANCIAL

The aforementioned Massachusetts study concluded that in 75 percent of the abuse cases cited, the abuser lived with the elderly person who was victimized. The abuser was a relative of the elderly victim in 84 percent of the citings. Other abusers may include staff or operators of foster homes, nursing homes, mental hospitals, etc. In other cases, mental or physical deterioration may result in older persons being unable to care for themselves on a day-to-day-basis. Hence the abuse under discussion here, may be inflicted by: relatives, paid caretakers, or the individuals themselves.

The kinds of abuse or neglect identified by researchers can be categorized as: physical, psychological, or financial/legal (misuse of assets, etc.).

Findings vary as the most frequent kind of abuse. While the University of Maryland study found that psychological abuse occurred most frequently, a study conducted by Elizabeth Lau at the Chronic Illness Center in Cleveland, Ohio, found that physical abuse was the most frequent. Lau found that almost three-fourths of the abuse studied involved physical abuse and over half involved psychological abuse. Further, the elderly clients in the study generally suffered from more than one kind of abuse.

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[1] Prepared as briefing material by the staff of the U.S. Senate Special Committee on Aging.

ELDER ABUSE JUST ONE COMPONENT OF FAMILY VIOLENCE

While information about elderly abuse is only now becoming available, recent studies on child abuse and spouse abuse indicate that abuse of the elderly is only one component of a larger problem; family violence. One expert on the subject has written that: "* * * the family is by far the most physically violent group or institution, except for the police or military at war." (Dr. Murray Straus, quoted in Jones, Jean Yarvis and Fowler, Jan., "Child Abuse: History, Legislation, and Issues," Congressional Research Services, Library of Congress, Washington, D.C., December 19, 1979, page 26.)

PROTECTIVE SERVICES: A TWO-HEADED CREATURE—PART SANTA CLAUS AND PART OGRE

In some instances, a mentally or physically infirm elderly person, who may fear the social worker or reprisals from a caretaker, refuses to accept essential medical, social, or other services. Since, unlike a child, an adult is competent until adjudicated otherwise, such a refusal may result in the need for legal intervention in order to authorize necessary protective services. This legal intervention could include guardianship, conservatorship (guardian of property), power of attorney, protective placement, or court-ordered services. This intervention also raises vital questions as to how much control society should exert over personal liberties:

> On the one hand are the ideals of personal choice, individual freedom, the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations. (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977, page 12.)

Not only do some victims refuse to acknowledge the problem, but many professionals who want to intervene cite a lack of legal protection for themselves and for victims, as well as a lack of shelters, funding services, and other resources.

STUDY STRESSES THE NEED FOR LAW

A 1977 report prepared by Prof. John J. Regan, then with University of Maryland Law School, and Georgia Springer, staff attorney, Legal Research and Services for the Elderly, National Council of Senior Citizens, cited the "* * * glaring need for reform of State laws concerning civil commitment, guardianship, and protective services." (Regan, J. J., "Protective Services for the Elderly," page 13.) It may be that the failure of States to reform laws (or to even address the problem at all) stems from circumstances similar to those encountered by the advocates of child abuse legislation: A reluctance to admit that the problems exist:

> Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's injury, or even death, is so repulsive that many are reluctant to believe it. (Jones, Jean Yavis and Flower, Jan, "Child Abuse," page 1.)

II. CAUSES OF ELDER ABUSE

STUDIES STRESS NEED FOR COMMUNITY-BASED SUPPORT SERVICES

Burston (1975) views battering of the elderly as a natural consequence of inadequate services to families who need support for caring for older family members. (Block, Marilyn R. and Sinnott, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979, page 80.)

The need for community-based services was also highlighted in a recent study on guardianship funded by the Administration on Aging. The study, issued in December 1979, stated:

> The need for guardianship is clearly related to the extent and quality of protective services. Given unlimited resources, most elderly now declared in-

> competent and institutionalized could be maintained in the community, particularly with the use of legal mechanisms less restrictive than guardianship (e.g., representative payee). (Schmidt, Winsor, C., et al., "Public Guardianship and the Elderly." Tallahassee, Fla., Florida State University Institute for Social Research, December 1979, page 121.)

In a similar vein, a recent Massachusetts study found that preventive strategies most often recommended by professionals and paraprofessionals surveyed included referral to social service agencies, counseling, arrangements for in-home services, and removal of the victim from the abusive situation. (Bergman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, page 2.)

Again, a 1977 study on protective services conducted for the Senate committee concluded that "* * * many tragedies might not occur if legal processes were geared to the task of obtaining support and services for elderly clients before they are forced from their homes." (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977.)

STRESS APPEARS TO BE CAUSE

"Like other abused dependents, elders are most often repeatedly abused by family members suffering from stress." (Block, Marilyn R., "The Battered Elder" page 80.)

ABUSIVE PERSON MAY ALSO BE OLDER AND UNDER GREAT STRESS

A study conducted in Cleveland, Ohio, found that as lifespans increase, caregivers who are themselves elderly, are more common. Community resources are generally less available to the elderly person cared for by family than to the isolated individual alone in the community. The result is often unrelenting stress of constant responsibility placed upon or accepted by a relative malequipped by personality, other responsibilities, skill, age, or financial resources, to successfully cope with the task. (Lau, Elizabeth E., "Abuse of the Elderly by Informal Care Providers: Practice and Research Issues," Chronic Illness Center, Cleveland, Ohio, November 20, 1978, page 10.)

UNEMPLOYMENT APPEARS TO BE ASSOCIATED

A major stress-producing condition within society is unemployment. This is supported by child abuse literature which indicates that nearly half of the fathers of abused children were not employed at some point during the year preceding the abusive act and 12 percent were unemployed at the actual time of the abusive act. (Block, Marily R., "The Battered Elder," page 12.)

MULTIPLE RESPONSIBILITIES

Persons who found caretaking difficult were often trying to meet the needs of their spouse and children, as well as the needs of the older relative. (Block, Marilyn R., "The Battered Elder," page 50.)

SUDDENNESS OF NEED FOR CARE

The extent of the conflict was largely dependent on whether the needs of the elder person increased slowly or rapidly. A sudden need for care is likely to cause greater tension, since the caregiver does not have an opportunity to prepare. (Block, Marilyn R., "The Battered Elder.")

AGEISM

Ageism—prejudices or negative feelings toward old age are prevalent in industrialized urbanized societies. These societies exclude the aging from continuing participation and contribution and subtly raise barriers to the availability of resources and services required:

> If we can * * * make life more fulfilling, more positive for the old so that they remain competent, companionable beings, we will certainly reduce considerably the number of elderly parents who are knocked down or verbally battered by their own exhausted children. (Block, Marilyn R., "The Battered Elder.")

PERSONALITY CONFLICTS, ROLE DEFINITIONS, AND PROBLEMS WITH COPING

Further, conflict between mothers and daughters have been discussed in terms of personality conflicts which were worsened by the passing of years and failure to redefine family roles can result in either latent hostility or possible overt violence. It has also been suggested that conflict between family members and the aged is most likely in situations where family members, either individually or as a family unit, have difficulty coping or if the parent is suffering from a chronic disease. (Block, Marilyn R., "The Battered Elder," page 11.)

ALMOST NO ONE IS IMMUNE

One researcher believes that almost no one is immune to the role of the abuser, if the discrepancy between situational demands (older person's problems, stress on caregiver) is great enough, although people vary in the degree to which they are prone to act in an abusive manner.

ITEM 4. SURVEY OF STATES ON PROTECTIVE SERVICES AND OTHER ISSUES

INTRODUCTION

The Senate Special Committee on Aging in March 1980, contacted all Governors and State legislative committees on aging to obtain information on adult protective services laws and a number of related issues. The following is a list of questions contained in the letter and a statement as to why they were asked:

1. THE NUMBER OF STATE ADULT PROTECTIVE SERVICES LAWS

Question: Does your State have a protective services law or has legislation creating such a law been introduced? If an elderly person in your State will not consent to the provision of protective services, what legal authority, if any, exists for requiring the person to accept protective services or protective placement. For the purposes of this question, protective services are services furnished to an elderly infirm, incapacitated, or protected person with the person's consent or appropriate legal authority, in order to assist the person in performing the activities of daily living, and thereby maintain independent living arrangements and avoid hazardous living conditions.

Explanation: As indicated earlier in this document, recent studies indicate that elder abuse may occur as often as child abuse. The fragmented information available on the topic indicates that States are responding to the problem by enacting adult protective services laws. The first question was designed to determine which States have enacted such laws.

2. THE PORTION OF OLDER PERSONS IN STATE MENTAL HOSPITALS

Question: How many persons are residing, either voluntarily or involuntarily, in your State mental hospitals? What percent of these people are over the age of 60? What percent of these elderly people could be returned to the community if appropriate support services were available?

Explanation: Protective services workers indicate that one of the major obstacles to dealing with elder abuse is finding appropriate placement for a person who must be removed from a dangerous situation. Too often the only alternatve is some form of institutional care.

Generally, the problems faced by protective services workers and courts are not unlike those faced by families and social workers in trying to place an older person who may be experiencing mental or physical deterioration. These difficulties with placement were explained in a 1977 report prepared for the Senate Special Committee on Aging. The report, entitled "Protective Services for the Elderly," discussed placement of older persons in institutions:

> Although most communities have resources for helping the elderly with mental and physical infirmities, they have been slow to respond sufficiently to the needs. This tardiness has exacted a terrible price in human tragedy, not to mention the exorbitant economic loss to the individual and to society.
>
> The human cost is seen in the appalling condition of the victims. Neglect of the aging person leads to withdrawal, increasing disorientation, mental

> disturbance, and physical deterioration. For those living in need of care, there is a constant threat of injury from fire, assault, or accident.
>
> At the same time, the elderly who are beneficiaries of social services may be at even higher risk of injury or death. When the elderly receive that attention, this may mean that the social workers and courts will put the client in an institution where both the enjoyment and length of life are curtailed. In addition to a shortened life, confinement in an institution usually means loss of self-esteem, of freedom, and of useful activity.
>
> For families and spouses, especially those without much money, the burden of caring for a disabled older person can be exhausting emotionally, financially, and physically. It is as painful to see a loved one decline as it is difficult to meet their needs, whether or not assisted by community resources. Yet the family often finds it even more heartbreaking to commit the patient to an institution.
>
> Present public policies of relying primarily on institutional care without providing other options are as damaging to society as to the individual involved.

Noninstitutional alternatives in long-term care are drawing increased attention at the local, State, and Federal level, as they play a crucial role in either keeping people out, or assisting with the removal of people from institutions.

In response to studies indicating that the elderly compose a large percent of those confined to mental institutions, coupled with the growing interest in alternatives in long-term care, the States were asked about the portion of elderly residents in their mental hospitals and about possible placement in the community.

3. LICENSURE OF SMALL, HOMELIKE FOSTER CARE RESIDENCES

Question: Are there any small, homelike foster care residences for adults in your State? If so, does your State have a law licensing, certifying, or in anyway regulating these foster homes? Are there foster homes only regulated when they serve more or less than a certain number of people? If so, please elaborate.

Explanation: This question was asked because homelike residences are an important form of community-based care in some States.

4. APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT

Question: In your opinion, what should be the Federal role in protecting older people from abuse or dangerous circumstances caused by their own mental or physical decline?

Explanation: Because the elder abuse being explored by the committee occurs within the confines of the family, the Federal Government must be mindful of individual and States' rights in trying to deal with the problem. As stated in the working paper on protective services, cited earlier, protective services laws that have been enacted by a number of States are part Santa Claus, part ogre:

> On the one hand are the ideals of personal choice, individual freedom, and the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations.

Aside from the question of individual rights, is the issue of States' rights. How can the Federal Government best proceed without circumventing the authority of the States?

STATE RESPONSES CATALOGED

1. STATE PROTECTIVE SERVICES LAWS

Before discussing the responses to the first question, it must be pointed out that adult protective services laws vary tremendously in scope. There is no clear guideline establishing what must be contained in a statute, or statutes, before a State can say it has an "adult protective services law." The committee attempted to compensate for the absence of a specific guideline by including a definition in its first question. In reading this section, it should therefore, be kept in mind that it simply catalogs the States' responses based on the committee's definition (see Introduction).

A. Half of the States Have an "Adult Protective Services Law"

Responses indicate that half (25) of the States have what the respondents consider an adult protective services law.

Different States, is should be noted, protect different people. Kansas, for example limits the provision of protective services to people in nursing homes or medical facilities operated by the State or Federal Government. Other States cover abuse or neglect of adults who live in the community.

In addition to the 25 States that have adult protective services laws, at least two, Nebraska and Minnesota, have laws that only require the reporting of abuse. No provision is made for the delivery of services. Other States have laws authorizing the provision of services, but do not require reporting.

The master chart, which follows, identifies which States indicated they have protective services laws and contains some descriptive information, as well.

B. Most Laws Passed in the Last 5 Years

The respondents were not asked when their State's adult protective services law passed. But, most volunteered the information. At least 16 of the laws were passed in the 5-year span from 1976–80; no fewer than 8 of these in 1977 alone.

C. Bills Before Many State Legislatures

Of the States without adult protective services laws, 14 have had adult protective services bills sponsored in their State legislatures, and 4 indicated that legislation is being developed.

II. THIRTY PERCENT OF THOSE IN STATE MENTAL HOSPITALS ARE ELDERLY

About 30 percent, 43,365 of the approximately 145,050 people in State mental hospitals, are elderly. Elderly in this case means age 60 or over. It is likely that it is a conservative estimate, because several States were only able to provide the committee with information on the residents age 65 and over.

It should also be noted that the figures provided the committee were not based on the population of State mental hospitals on one specific date or month. The time frame during which the figures were collected varies by a period of up to several months. Consequently, these figures should be viewed as estimates.

Not surprisingly, the percent of older people in State mental hospitals varies greatly: from a low of 1–3 percent in Alaska to approximately 50 percent in Pennsylvania and Virginia.

The portion of elderly residents who could be discharged if appropriate services were available varies still more: From almost no one in Wisconsin—which has long emphasized community-based mental health care—to almost all elderly State hospital residents in other States.

III. VAST MAJORITY OF STATES LICENSE SMALL, HOMELIKE FOSTER CARE RESIDENTS

As the master chart indicates, almost all States have laws requiring the licensure of small, homelike foster care residences for adults. While the name for this kind of facility varies from State to State, they are usually licensed under laws that are specifically developed for homes serving fewer than anywhere from two to five people.

IV. THE APPROPRIATE FEDERAL ROLE

Generally, the most frequent response indicated that the Federal Government could be most helpful by providing additional funding for the implementation of State protective services programs. In many cases, the importance of increase title XX funding was stressed.

The respondents also stressed the need for the Federal Government to encourage—or even mandate—States to enact protective services laws.

The need for information and training in the area was frequently mentioned, and suggestions were also made for policy changes.

The following outline summarizes States' comments on the appropriate Federal role. It is interesting to note that many of the comments are equally applicable for State government action.

Response	*States* [1]
I. Need for money:	
A. To fund protective services programs in States	8
B. To expand other in-home services	3
C. To create shelters	2
D. To fund research and demonstration projects	1
II. Need for State protective services laws:	
A. Encourage States to develop protective services legislation	3
B. Mandate States to develop and enact protective services legislation	5
C. Specifically mentioned national approach similar to that used in child abuse	2
D. Develop model protective services legislation	4
E. Establish uniform guidelines or standards for the provision of protective services	3
III. Need for information:	
A. Federal Government to provide technical assistance/training	4
B. Federal Government to establish clearinghouse	3
C. Need to educate public	2
IV. Policy changes:	
A. Allow title XX to offer services on an emergency basis for a limited time, regardless of income	1
B. Expand rights of elderly boarding home residents to be as broad as nursing home residents (i.e., ombudsman program)	2

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[1] Number of States giving this response.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Alabama	Yes. Passed in 1977		2,384	20 (476 people)		Establish standards and provide funding to enable the States to develop programs to prevent elder abuse through public education, outreach, and enforcement.	No homes no laws	
Alaska	No		235	About 2 (5 people)	70 (2 people)	Provide technical assistance.		
Arizona	Yes. Passed in 1980		300	40 (120 to 125, people)	20 (about 80 percent would be in nursing homes)	Provide funding for protective services programs.	License foster homes which may not have more than 5 people.	
Arkansas	Yes. Passed in 1977		266	9 (25 people)		Expand medicaid regulations provisions for advocates and ombudsmen to boarding homes and other residential settings.		
California	No. No comprehensive law at this time.	Conservatorship law with due process provisions enacted in 1977.	5,314	9.7 (516 people)	Not known	Until authorities determine what is wisest way to treat elder abuse, it is difficult to determine which level of Government should take action.	License 4,207 "small family homes for adults" for people needing some care and supervision.	
Colorado	No. 1980 reporting bill introduced, but was not passed due to lack of funding.		984	11 (108 people)	Approximately 56 (60 people).	Develop legislation to insure "uniform provision of services" to abused elderly.	License homes from 1 to 15 people. State and counties supplement payments.	
Connecticut	Yes. Passed in 1978	If won't accept services, a conservator is appointed.	2,211	14 (314 people)	Not sure, but figure it would be substantial.	If anything, mandate that States develop some system for responding to elderly abuse.	License any facility that houses 2 or more elderly persons and provides more than room, board, and laundry.	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Delaware	No.		519	22 (114 people)	Only because 3 have a well-developed foster care program.	Gather and disseminate statistics and documentation of older people living in dangerous circumstances. Provide additional money for public advocacy in OAA for protective services.	Yes. Only those that serve 1 person are exempted.	
Florida	Yes. Passed in 1977		5,174	30 (1,527 people)	No information on 60 plus, but by July 1980, expect to refer 46 percent of 55 plus patients for discharge.	Provide funding to encourage States to develop protective services program through programs like title XX.	License foster homes and adult congregate living facilities.	Community based State programs for elderly in Florida include: (1) Home care, pays family or friend to care for elderly; (2) "Community care for elederly" to pay for services like respite care, day care, transportation.
Georgia	No. Bill introduced, but not reported by House Judiciary Committee.	Unless can find a guardian cannot intervene on behalf of older person—guardianship statute revised in 1969—Department of Human Resources may be guardian.	5,569	21 (1,175 people)	25 to 50. An additional 35 percent if nursing homes considered appropriate.	Make sure Federal laws and regulations don't interfere with a person's rights. Cites legislation empowering U.S. Attorney General to intervene when nursing home residents' rights are violated as superb.	License homes according to size.	
Hawaii	No. Legislation introduced in 1975 but did not pass.		255	10 (22 people)		Legislate mandatory minimum standards for States in provision of protective services. Provide for research and training grants, as per child abuse.	License homes according to number served (4 is break-off number for various homes).	

Idaho	No. Draft legislation developed but not introduced.	Have a "progressive" guardianship law.	232	22 (51 people)	36 (8 people)	Direct Department of Justice to develop model adult protective law.	Have shelter care licensure for facilities caring for 3 or more people.	Have trouble finding guardians for poor people.
Illinois	No. Bill before Illinois Legislature would create special legislative commission to study elderly abuse.	Have a new guardianship and advocacy program, which became effective in 1980.	10, 240	7 (685 people) (was 10,000 a decade ago).	Only residents who cannot be cared for in the community are cared for in the hospital.	Encourage examination, review and identification of elder abuse.	Have a small program, only 340 people statewide. VA has about 250 people but there is no licensure law just department standards (Public Health Department).	
Indiana	No. But, commission on aging is working on one.		5, 060	17 (865 people)	No answer	Provide for public education.	Have licensure laws for various sized homes.	
Iowa	No. No law or pending legislation.		1, 040	22 (228 people)	100	Establish firm criteria in guiding States in protecting adults.	License residential care facilities for 4 or more beds.	
Kansas	Yes. Became effective July 1, 1980. But is limited to people in nursing homes or medical facilities operated by State or Federal Government. Also have protection from abuse act.		[1]1, 200	Approximately 10 (120 people).	95 percent could return, depending on definition of support services.	Develop model legislation on abuse reporting and hearings to show that the problem exists. Promote a program for alternate living arrangements.	License: "1-bed adult care homes" as well as "2-bed" homes. Also license boarding homes for 3 or more people.	Abused adult can either seek redress under criminal statutes or from "protection from abuse act" if they are abused by a family member.
Kentucky	Yes. Enacted 1976, revised 1978 and 1980. The law requires reporting and provides for emergency services for those who can't care for themselves.		780	20 (157 people)	23	Set standards and encourage States to enact adult protective services laws.	Have "family care homes." Require licensing if care for 2 to 3 people. If 3 or more are licensed as personal care homes.	
Louisiana	No. But a bill is before the legislature.		2, 083	15 (317 people)	No answer	Develop national clearinghouse for elder abuse information. Fund protective services programs. Designate people on national and regional levels as consultants.	No	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws.	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Maine	Yes. Involuntary protective services must be provided through public or private guardianship.		630	40 (252 people)	32 to 38.2 percent could be returned according to a study.	Fund and require State protective services laws.	Adult foster home program licenses homes for 4 or fewer people.	
Maryland	Yes. Became effective in 1977.		3,637	36.3 (1,320 people)	38 (23 percent in nursing home, 15 percent in family setting).	Federal Government should require all States to enact guardianship laws.	No statewide licensure program, but counties do license, though standards vary.	
Massachusetts	No. Legislation before legislature, but already have a law "dealing with prevention of abuse in general."		[2] 2,000	30 (600 people)	Very few	Should fund more for title XX. The Federal Government should act as a clearinghouse for information on elder abuse.	Have some facilities and these are subject to State building codes.	
Michigan	Yes. Act No. 136 of the Public Acts of 1976 and sec. 68 of 1978–79 Appropriations Act. Bill in 1980 would require reporting, confidentiality and immunity.	New probate court code and mental health code gives probate courts the authority to appoint guardians and conservators of adults who are unable to manage finances.	[3] 4,807	16 (759 people mentally incompetent).	28.1		Have 3,012 adult foster care facilities licensed to serve 18,836 people.	Goal of guardianship and mental health law is to maintain person in least restrictive setting.
			[4] 4,974	3 (151 people mentally retarded).	26.9			Law does not require reporting.
Minnesota	Reporting law only. Sponsored for first time and passed in 1980.		4,893	8 (387 people)	1 or 2 people, if any	Develop a national policy for dealing with adult abuse. Make sure that all agencies working on the problem coordinate work.	No State licensure law in foster-type homes.	Minnesota has been working on deinstitutionalizing its mental hospitals since the mid-1950's. Will soon be closing one, and possibly more.

Mississippi	No. Bill introduced in 1980 but not reported out of committee.		2,285	39 (891 people)	60 percent with nursing homes 10 to 15 percent without.	Funding of protective services. Set minimum "care" standards to apply in the absence of State law.	No licensure of boarding homes, though they exist. No foster care-type homes. Do license personal care homes.
Missouri	Yes. Passed in 1980. Consent required for the provision of services, unless a person is first declared incompetent.	No legal right to intervene against a person's wishes.	[a]2,631	26.7 (704 people) 8 (29 people of those in mental health centers)		More emphasis should be placed on prevention. Need more money for rural health needs.	Bill before legislature would pay relatives to provide foster care.
Montana	Yes. Statute does not define abuse, exploitation, neglect, etc. Does not have a reporting provision.	Use guardianship law to provide protective services involuntarily, use public or private guardians.	514	31 (218 people)	13 (67 people)	Support budget requests for title XX protective services and require States to pass model protective services legislation.	License for 4 or more people.
Nebraska	Has a reporting law, but services to be provided are in directives issued by Division of Social Services, not in law.	Cannot provide services involuntarily.	582	13 (76 people)	Respondent said question is "moot."	Change title XX to allow social services to be provided without regard to income on an emergency basis for a limited time (90 days). Require resources to be coordinated.	Have 260 licensed adult family homes. Have 26 custodial foster homes with 849 beds for more structured environment.
Nevada	No. Bill introduced in 1979, but did not pass. Bill dealt with people over 18.		152	12 (17 people)	Not applicable. State hospital beds are for acute/crisis care only. Don't have chronic back-ward patients.		No licensure law. But welfare division certifies homes that care for 3 or more people who receive State SSI supplements.
New Hampshire	Yes. Enacted in 1977. Must petition for guardianship or temporary guardianship to provide involuntary protective services.		782	32 (251 people)			Regulate all homes that provide care or supervision to adults; but not those that provide room and board.

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of these elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
New Jersey	No. A reporting bill is being reviewed by the Assembly.		3,929	42 (1,645 people)			New law requires that boarding homes, rest homes, or other homes for the sheltered care of 4 or more adults be subject to State regulation, approval and inspection. But, have no small homelike foster care residence for adults.	
New Mexico	No. Bill sponsored in 1979, but did not pass.	Provision in probate code is only legal authority for providing adult involuntary protective services.	237	27 (64 people)	10	Should mandate and fund same protection for adults as for children.	No foster care exactly but have many adult residential shelter care and boarding homes with 6 or fewer residents.	
New York	Yes. In 1979 it was expanded to cover all individuals incapable of managing themselves, not just SSI recipients.	A recent "State task force on protective services for adults" targeted involuntary intervention as one of the major areas for study. Now can't provide services to someone who won't accept them, but legislation is pending.	25,041	53 (13,286 people)		Strongly emphasize protective services in Federal legislation. Fund protective services with local and State flexible allotment.		Not sure should go route of child abuse act, because not sure of program's value. Therefore, go with demonstration programs first. Mentioned the importance of housing and home services in solving problems.
North Carolina	Yes. Contains reporting provision.		3,375	23 (1,181 people)	75 to 80	Eliminate title XX ceiling.	License family care homes for 2 to 5 people.	
North Dakota	No. Agency personnel are working on a draft bill.		564	34 (192 people)		Needs to take an active role as in child abuse. Do national conference on topic.	Have a licensure law but not a well established statewide foster care program.	
Ohio	No. Bill before legislature now, but was not passed due to gap in coverage, which left the 18–54 yr. olds uncovered.		11,074	20 (2,165 people)			License foster homes for not more than 5 people, at least 1 who receives SSI. Group home for 6 to 16, licensed, at least 1 on SSI.	

Oklahoma	Yes. Law passed in 1977. "Elderly" person is defined as someone 65 or older. Authorizes involuntary protective services with a court order, if person lacks capacity to consent to services and is suffering from abuse, neglect, or exploitation presenting a substantial risk of death or immediate serious harm to himself.		1,518	26 (392 people)	Not known.	Federal role should be providing grants to States to study the problem and implement requirements based on State need.	No law has been implemented due to lack of funding and documentation of need.	
Oregon	Yes. Statutory authority is only 1 sentence long. Simply directs State agency to develop regulations for the provision of "social services, including protection, to those individuals in need of, or who request such services."	Guardianship, etc., may be used to provide protective services without consent.	1,192	5.9 (have been stressing community placement) (82 people).	2	Encourage States to develop comprehensive protective services programs. Increase title XX funding for protective services.	Has 850 certified adult foster care homes, for 5 or fewer people.	State is currently researching possibility of establishing a social service system to serve abused elderly.
Pennsylvania	No. But several bills introduced. Now provide protective services to people involuntarily through mental health procedures act or incompetent estates act.		10,500	50 (5,250 people)	No answer, but currently discharge less than 1 percent of people over 60.		State has a domiciliary care program, certified by area agencies on aging for SSI recipients. Are also 30 county-operated foster homes for those residents who are usually healthier than domiciliary care.	
Rhode Island	Yes. Provide protective services only on voluntary basis. Reporting bill filed in 1980, as was legislation creating limited guardianship and conservatorship.		666	19 (127 people)	15 to 20 people		Have no group homes just for the elderly, but all group homes are licensed.	
South Carolina	Yes		3,550	43 (1,537 people)	28 (427 people)	Conduct workshops in States that don't have protective services laws. Develop model legislation.	Adult residential facilities and licensed for 2 or more.	
South Dakota	Yes		457	40 (183 people)	50		License 183 facilities	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
ennessee	Yes. Passed in 1978. Applies to anyone 18 or over, who because of mental or physical dysfunctioning or advanced age (60 plus), is unable to care for self (paraphrased).	Court can order that services be provided involuntarily in life threatening situations. Requires that the person have counsel.	2,718	30.5 (895 people)	5		Depending on kind and size of home, have a variety of licenses, starting with homes with 1 or more unrelated people.	Also have State homes operated by department of Human Services and licensed by Department of Public Health.
exas	No. But several bills have been introduced.		[illegible],518	27.48 (437 people)		Provide funding	License approximately 200 foster family care homes with up to 3 people. Homes with 4 or more are licensed as long term care.	
tah	Yes. Has a law (since 1977) that spells out provisions for assisting elderly people who will not consent to provision of protective services.		310	16 (50 people)	50 (25 people)	Provide funding. Also provide consultive services and act as a clearing house for information and training.	Do not license, but certify and approve adults foster homes for up to 3 people.	
ermont	Yes. Law passed April 1980.		286	29 (83 people)	45 total people. 15 people to nursing homes. 30 people to other settings.	Educate country about problem. Mandate that each State enact protective services legislature.	License "community care homes."	
irginia	Yes. Passed 1977		4,876	48.9 (2,433 people)	25 (608 people)	Encourage States to enact protective services laws. Establish national policy for continuance of in-home services. developed in concert with voluntary sector. Simplify coordination by medical and social services and case management. Channel money away from institutions to community-based care. Initiate national public awareness effort.	License homes for 4 or more people.	

Washington	No	Can provide supportive treatment under: Guardianship (also limited guardianship); involuntary commitment; reporting and investigation required of nursing homes.	3,980	9.3 (371 people)	[6] 18.7	Housing: Assist in creation and funding of shelter facilities. Training of adult protective services staff and care givers of abused adults. Research-demonstration projects.	License adult family homes that serve a maximum of 4 people. There are 400 homes, 235 of which have a contract with State.	
West Virginia	No. Bills introduced for past 5 years, but since Department of Welfare can provide service it thinks is necessary, it has issued guidelines for delivering protective services.	No agency has authority to provide services involuntarily (has been very controversial issue in legislation).	2,224	23 (523 people)	Not sure	Require States to pass protective services law, which should require that a lead agency be designated.	Has 780 approved adult family care homes for 1 to 3 elderly people.	Have trouble recruiting adult family care homes because reimbursement is so low ($195 to $265) per month.
Wisconsin	Yes. Passed in 1973. No reporting provision.	Can only be given services involuntarily if have a guardian, however, may be placed under protective placement if there is a probability of irreparable injury at death.	[2] 500	5 (25 people)	None. Place much emphasis on community mental health care.	Provide flexible block grants, so that States can fund services they think are important.	License adult family homes for 1 or 2 and community-based residential for 3 or more.	Think Federal Government should assist States develop noninstitutional support service. Now availability of funds determines programs, not appropriateness.
Wyoming	No. State is working on preparing one that will deal with abuse of all people, not just elderly.		279	22 (60 people)	25 (15 to 20 people)	Establish a Federal adult abuse registry, develop training sessions and resource material and funding for such projects.	In accordance with the Key's amendment in Federal law (Public Law 94-566) they have established minimum standards for foster homes serving SSI recipients.	

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[1] Also has a 122-bed secure intermediate care facility.
[2] Approximately.
[3] Mentally incompetent.
[4] Mentally retarded.
[5] In addition 350 in mental health centers.
[6] 18.7 percent is as follows: 3.2 percent could be independent. 9.1 percent to congregate care or nursing homes. 6.4 percent could go to residential care if had special mental health treatment.

ITEM 5. LETTER AND ENCLOSURE FROM JUDITH S. McLAUGHLIN, R.N., C.N.A., ASSOCIATE DIRECTOR, YORK COUNTY HEALTH SERVICES, SACO, MAINE, TO RON FRIED, STAFF MEMBER, HOUSE SELECT COMMITTEE ON AGING, DATED JUNE 5, 1980

DEAR RON: Attached is a copy of a paper on "Elder Abuse" which I did with two other graduate students from Southern New Hampshire this past semester. Although it is necessarily academic in tone, I thought some parts of it may be of interest for the hearing on Elder Abuse scheduled for June 11. I realize it may just reach you by that date, but I received the Select Committee's May 28 newsletter announcing the hearing today—and am glad that this issue is being examined.

I also hope that the Massachusetts study cited in the bibliography has reached you, for it contains some excellent data. Clearly this is a problem worthy of serious attention in the 1980's, and one I believe can be readily addressed by systems and services already in place, once general recognition takes place.

Thanks for keeping me in touch with committee proceedings.

Warm regards,

JUDITH S. McLAUGHLIN, R.N., C.N.A.

Enclosure.

ACKNOWLEDGMENTS

In the accomplishment of this project, we are indebted to several people. Without their interest and cooperation, the data would be scanty indeed, as would our ability to make recommendations or draw conclusions. Instead, each contributed an idea or suggestion which spurred us on.

Particular appreciation is extended to:

HOSPITAL PERSONNEL

Edward McGeachey, M.S.W., assistant executive director, Webber Hospital Association, Biddeford, Maine.

Emergency room, Portsmouth Hospital, charge nurse, and chief of emergency medicine.

Lois Kilroy, R.N., supervisory nurse, Edgewood Manor Extended Care Facility, Portsmouth, N.H.

Mary Ann Peters, nursing director, Wentworth Douglas Hospital, Dover, N.H.

SENIOR CITIZENS GROUPS

Lawrence Gross, project director, Southern Maine Senior Citizens, Portland, Maine.

Phyllis Gray, elderly advocate supervisor in York County, Southern Maine Senior Citizens, Portland, Maine.

Dorothea Reed, director of the Council of Senior Citizens, Portsmouth, N.H.

CIVIL, LEGAL, OR GOVERNMENTAL AGENCIES

Lester Bennett, supervisor, Adult Protective Services, region I, Maine Department of Human Services, Portland, Maine.

Roger Nadeau, deputy chief of police, Saco, Maine.

——— Hendricks, detective, Biddeford, Maine, Police Department.

Mrs. Haven, Legislative Engrossment Department, State House, Augusta, Maine.

Chief Reynolds, Dover Police Department, Dover, N.H.

Ann Thibodeau, social gerontologist, Pine Tree Legal Assistance, Portland, Maine.

Intake officers, officers for adult services, and officers on the beat with the Portsmouth, N.H., Police Department.

Susan Turner, N.H. Legal Aid Association, Portsmouth, N.H.

SOCIAL SERVICE OR INFORMATION/REFERRAL

Mrs. Czerwinski, Caring Unlimited, Biddeford, Maine.

David, social worker, info line, information and referral, Concord, N.H.

Info-Center, Newmarket, N.H.

Cecile Gagne, administrative staff, Strafford County Homemaker/Home Health Aide Association of New Hampshire.

Gail Bell, social worker, Division of Welfare, Strafford County, Dover, N.H.
Murray Straus, Ph. D., professor of sociology, University of New Hampshire, Dover, N.H.
Lee Ballard, director of Homemaker-Home Health Aide Service.

OTHER COMMUNITY HEALTH GROUPS/AGENCIES

Beverly Tirrell, executive director, South Portland Health Services, Inc., South Portland, Maine.
Ann O'Neil, adult health clinic program coordinator, York County Health Services, Inc., Saco, Maine.
Shirley A. Ouprie, executive director, York County Health Services, Inc., Saco, Maine.
Suzanne Griffith, nursing director, Oyster River Home Health Association, Durham, N.H.
Susan Karmeris, public health nurse, Division of Public Health of New Hampshire.
Betty Burtt, R.N., director of public health nursing, State of New Hampshire, Concord, N.H.
Nancy Boyle, R.N., director, Dover V.N.A., Dover, N.H.

OTHER HEALTH PROFESSIONALS

Connie Theberge, L.P.N., physician's office, Dover, N.H.
Laurice Jackson, maternal and child health coordinator, Tri-Area V.N.A., Somersworth, N.H.

Also, without the many hours over the typewriter by Michelle Trottier, YCHS; Brenda Shure and Barbara Cook PCHS; and Kim Ladashun of Somersworth, N.H., this project would not be either legible or complete. These are the real heroines of graduate student days.

AN EPIDEMIOLOGICAL INVESTIGATION OF ELDERLY ABUSE IN SOUTHERN MAINE AND NEW HAMPSHIRE, 1979-80, BY JUDITH S. McLAUGHLIN, JOAN P. NICKELL, AND LINDA GILL[1]

Chapter I

INTRODUCTION

BACKGROUND OF THE PROBLEM

Several major changes in health care and American society have occurred in the 20th century. More Americans today live to older age than ever before, and the proportion of people with health problems increases with age. In 1900, 4 percent of the population were over 65 years; in 1980 an estimated 13 percent are over 65. Improvements in communicable disease control measures, coupled with rapid and significant advances in pharmacological and technological treatment of disease conditions, are reflected in increased chronic and disabling morbidity in the population—particularly the elderly. "Eighty percent of our older people have one or more chronic conditions and their medical treatment accounts for about 30 percent of the Nation's health care expenditures" (USDHEW, 1979, page 71).

The high cost of institutional care, as well as its dehumanizing effects, has created an effective political lobby among elderly Americans, resulting in a broad range of Federal, State, and local health and social service programs to provide a support system to the frail elderly in the community. The "wellness revolution," or movement toward increased personal responsibility for self-care and concern with the quality of life, is evidenced in human rights movements as well as definitions of health which emphasize self-actualization, broader than merely the absence of disease. One result of this holistic focus is evidenced by increased public awareness of and indignation about abuse and neglect of children, and more recently, battered women, focusing in more attention on family violence as a health and social problem. The subtle convergence of all of these trends has led us to examine the emerging phenomenon of abuse and neglect in the elderly population.

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[1] Submitted to Nancy Zaris, M.S.N., in partial fulfillment of the requirements for CH760. The Graduate Division, School of Nursing, Boston University, April 22, 1980.

STATEMENT OF THE PROBLEM

"Neglect and abuse may be viewed as a continuum that ranges from inattention to * * * basic human needs * * * to physical battering, emotional trauma, or even death" (Johnson, D., 1979). Abuse and neglect of elderly persons (host) at home (environment) by family members (agent), most often their adult children, is recognized as a health and social problem in Massachusetts (O'Malley, et al., 1979) and Maryland ("Pacific Stars and Stripes," December 1979). There is no reason to believe that this problem is confined by geographic or socioeconomic boundaries, yet its magnitude is unknown in southern Maine and New Hampshire. Recognition of the potential for abuse and neglect in the growing number of elderly at home, often living in multigenerational families, is necessary to determine its magnitude and nature, in order to affect public policy.

SIGNIFICANCE OF THE PROBLEM

As medicare certified and nationally accredited community/home health agencies, both Portsmouth Community Health Services, Inc. (PCHS), and York County Health Services, Inc. (YCHS), provide interdisciplinary coordinated and comprehensive home health services. Recently, the emphasis has moved to extended hours and a flexible service mix to also provide long-term in-home care and support to delay or prevent institutionalization of more elderly persons in the populations served. Because both agencies provide intermittent care primarily on a visiting rather than shift basis, teaching family members, neighbors, and volunteer caretakers to provide maintenance personal care and socialization between home health visits is essential to a safe and adequate care plan. Just as child abuse and battered wife syndrome take a toll in violated human rights, economic health care costs, and family separation, the stress of role reversal and a daily routine which inhibits the personal freedom of families creates conflict which threatens family structure at the end of life.

National population data indicate that 11 percent were age 65 and over in 1977; the catchment areas for both PCHS and YCHS are slightly above at 14 and 12.4 percent respectively. Although such in-home care is not limited to elderly persons, 56 percent of clients admitted to York County Health Services', Inc., home care program and 72 percent of Portsmouth Community Health Services', Inc., home care caseload during the 18 months between July 1, 1978, and December 1979, were over 65 years old. Both agencies have noted a few isolated instances of neglect and have questioned actual physical abuse (PHSC and YCHS statistics). Most problems stem from the family's inability or reluctance to adequately care for the bedridden or severly debilitated elderly parent or relative, and barriers to resolution have been identified in the legal system, official agencies, and community values. Thus, both agencies are working with at least a portion of the population at risk for elderly abuse.

Table 1 and figures 1 and 2 show selected study population characteristics:

Table 1

Proportion of elderly in the population served
by PCHS and YCHS, FY 79-80,
in relation to U.S. and State

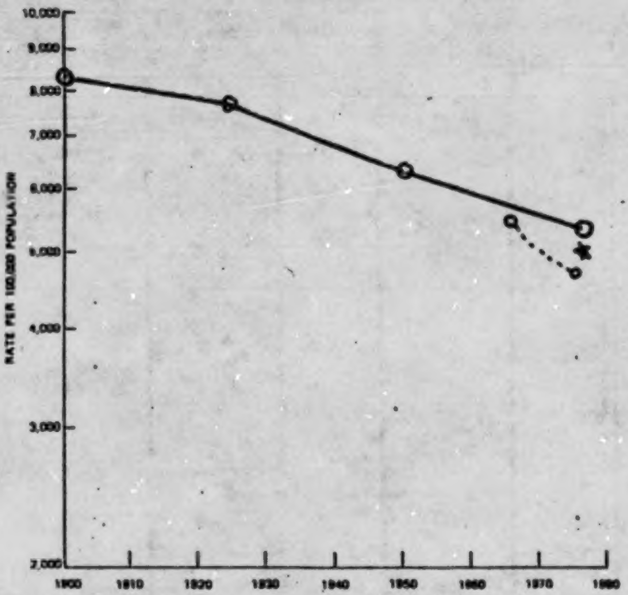
United States*			State**			Catchment Area***		
Total	65+	%	Total	65+	%	Total	65+	%
218 mil.	24 mil.	11	1,105,022 (Maine)	127,077	11.5	129,010 (York County, ME)	15,094	11.7
						32,700 (Biddeford-Saco, ME)	4,034	12.4
			871,500 (New Hampshire)	99,000	11.4	180,000 (Rockingham County, N.H.)	17,000	9.4
						23,600 (Portsmouth, N.H.)	3,304	14.0

*U.S. DHEW, 1979

**State of Maine Planning Office, 1979/United Health Systems Agency, N.H., 1977

***YCHS, 1979; PCHS, 1979

FIGURE 1.—Death rates for ages 65 years and over: United States, selected years 1900–1977



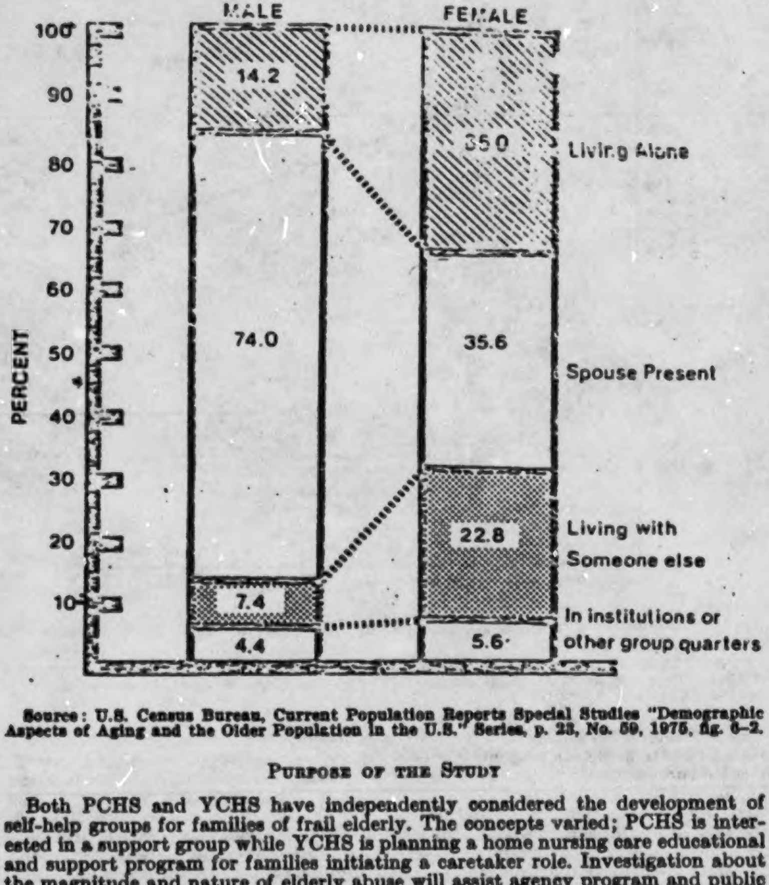
Note: 1977 data are provisional; data for all other years are final. Selected years are 1900, 1925, 1950, 1977.

Source: National Center for Health Statistics, Division of Vital Statistics ○—○, State of Maine Department of Vital Statistics, 1977 ○----○. State of New Hampshire Department of Vital Statistics, 1978 .★

In the fall of 1979, the Pine Tree Association of Community Health Agencies, Maine's State association of community/home health agencies, conducted a study of all clients over 60 years of age admitted for home health care. The Grauer-Birnham Functional Rating Scale, a nationally recognized and valid tool, was used. Forty-eight percent or 164 of the 343 clients studies scored less than 20 points, a score indicating that nursing home, chronic disease hospital, or psychiatric facility placement would be necessary if supportive services were not provided by some combination of professional nursing, therapy, and family home care. Another 77 or 22.4 percent of clients scored between 20 and 40 points, indicating boarding home or other supervised domiciliary care would be required (YCHS, September–October, 1979). These results correlate with those of Brody (1978) who found that a caring cluster or support unit was more significant to decisions about community or institutional living than the degree of impairment (page 5581).

National data indicate that most elderly are vigorous, independent, and live at home—77 percent had their own households, 51 percent lived with a spouse, 26 percent lived alone, and 18 percent lived with siblings or children in 1975. However, 45 percent had activity limitations and 20 percent of these are "handicapped in their ability to move freely" (USDHEW, 1979, page 74). The similiarity of functional ability/disability percentages in the national population with those served by YCHS is not directly comparable, but speaks to a significant segment of both national and local population whose situation contains the epidemiological factors of the elder abuse and neglect problem. In this year of preparation for the White House Conference on Families, this study is particularly functional as an impetus for public and health policy (Center for Woman Policy Studies, January 1980, page 7).

FIGURE 2.—Percent distribution of the male and female population 65 years old and over by living arrangements: 1975 (Mindell, 1979, p. 456)



Source: U.S. Census Bureau, Current Population Reports Special Studies "Demographic Aspects of Aging and the Older Population in the U.S." Series, p. 23, No. 59, 1975, fig. 6-2.

PURPOSE OF THE STUDY

Both PCHS and YCHS have independently considered the development of self-help groups for families of frail elderly. The concepts varied; PCHS is interested in a support group while YCHS is planning a home nursing care educational and support program for families initiating a caretaker role. Investigation about the magnitude and nature of elderly abuse will assist agency program and public policy development in both Maine and New Hampshire, both as a systematic needs assessment and epidemiological framework for intervention strategies. The objectives of such preventive health education and support groups will be increasingly specific rather than intuitive by application of the results of this study. A profile of the abuse/neglected elder (host), his/her family member(s) (agent), and the situational factors which surround abuse/neglect (environment) will suggest critical points of health care, legal, or social service intervention to detect occurence/reoccurence of the problem.

RATIONALE FOR THE STUDY

Child abuse and battered wife syndromes are known to exist in PCHS and YCHS catchment areas, and services are marshaled for treatment and detection. However, the data base for elderly abuse and neglect is unknown. The logical first step is to gather what information is available in order to support or deny the need for community health programs designed to intervene. Therefore, this study was undertaken to examine the following:

—What is known about the prevalence of elderly abuse and neglect in Portsmouth, N.H., and Biddeford-Saco, Maine?

—What are the dynamics of time, person, and place variables in the neglected or abused elder's family?
—Are the causes of elderly abuse and neglect primarily familial or societal, or both?
—What community resources exist, or should exist, to prevent the problem of elder abuse and neglect?
—Do our communities condone, contribute to, or perpetuate elderly abuse and neglect by a lack of recognition of the problem?
—What is the appropriate role for community health nurses and agencies in elderly abuse and neglect?

HYPOTHESIS

(1) Elderly abuse and neglect is a heretofore unrecognized health problem in southern New Hampshire and Maine.

(2) Community health agencies can contribute to the detection and prevention of elderly abuse and neglect in the populations they serve.

ASSUMPTIONS

This study was based on the following assumptions:

(1) That health and social service personnel in the PCHS and YCHS catchment areas were able and willing to supply data.

(2) That the Portsmouth, N.H., and Biddeford-Saco, Maine, populations were similar in composition, size, and proportion of elderly to make correlations and draw conclusions.

(3) That abuse and neglect is an undesirable state for families and the community as a whole.

(4) That study results were desired by administrators, planners, elderly advocates, and policymakers, and would positively influence health and social service delivery.

(5) That interviews and questionnaires were reasonably valid and reliable methods for obtaining data.

SCOPE AND LIMITATIONS OF THE STUDY

The search phase for available data was not confined to the PCHS and YCHS catchment area, but included selected statewide contacts. The study phase was, however, delimited as follows:

(1) To the period from July 1, 1978, to December 31, 1979, or to a recent 18-month period.

(2) To recollections of the professional community health nurses serving Portsmouth, N.H. (1979 estimated population 23,600, 14 percent over 65 years), and Biddeford-Saco, Maine (1979 estimated population 32,700, 12.4 percent over 65 years).

(3) To the review of the literature published between 1975 and 1980, concentrating on 1978–80.

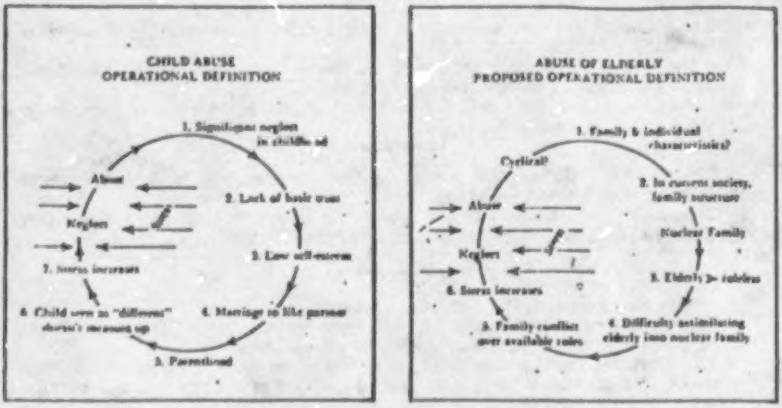
(4) To library resources at: (a) The University of Southern Maine; (b) the University of New Hampshire; (c) the New England Gerontology Center; (d) Portsmouth Community Health Services, Inc.; (e) York County Health Services, Inc.; (f) the Division of Public Health Nursing, State of New Hampshire; (g) the Division of Welfare, State of New Hampshire, Strafford County Office; (h) The researchers' personal reference collections.

TERMINOLOGY

(1) *Abuse:* "The willful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement, or willful deprivation by a caretaker of services which are necessary to maintain mental and physical health" (O'Malley, et al., 1979, page 2). Can also be self-abuse, "as in subintentional suicidal behavior in one who lives alone" (Lau E., and Kosberg, J., 1979, page 11).

Figure 3 suggests an operational definition of elderly abuse, in comparison to the phenomena of child abuse:

FIGURE 3.—Comparison of proposed operational definition of elderly abuse with accepted child abuse model. (Johnson, D., 1979, p. 12)


CHILD ABUSE
OPERATIONAL DEFINITION
1. Significant neglect in childhood
2. Lack of basic trust
3. Low self-esteem
4. Marriage to like partner
5. Parenthood
6. Child seen as "different" doesn't measure up
7. Stress increases
Abuse
Neglect
ABUSE OF ELDERLY
PROPOSED OPERATIONAL DEFINITION
1. Family & individual characteristics?
Cyclical?
2. In current society, family structure
Nuclear Family
4. Difficulty assimilating elderly into nuclear family
5. Family conflict over available roles
6. Stress increases
Abuse
Neglect

(2) *Neglect:* The intentional failure to meet basic health/survival needs, primarily of four types; physical, psychological, material/ financial needs, and violation of human and civil rights (adapted from Johnson, D., 1979, and Lau and Kosberg, 1979; pages 11–12).

(3) *Elder (Elderly):* Any person sixty-five (65) years of age or older and residing in a noninstitutional setting, including persons living alone, with family or friends, or with a caretaker (O'Malley, et al., 1979, page 2).

(4) *Health:* A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization 1948).

(5) *Community/Home Health Agency:* An organization legally authorized to provide nursing, rehabilitative therapies, and health aides to groups or individuals in their homes or communities. Usually certified as meeting the conditions of participation in title XVIII (medicare) of the Social Security Act. The accrediting body is the National League for Nursing/American Public Health Association.

(6) *York County:* The southernmost county covering 1,001 square miles of Maine; bordered south and east by the Atlantic Ocean, and New Hampshire, and Cumberland and Oxford Counties to the north. It is the third largest of Maine's 16 counties and accounts for approximately 12 percent of Maine's population. Biddeford and Saco are the most densely populated towns in York County.

(7) *Rockingham County:* The southernmost county of New Hampshire covering 244 square miles, bordered on the south by Massachusetts. Portsmouth is the largest seaport in New Hampshire, surrounded by both a naval base and air force facility.

STUDY PROCEDURES/DESIGN

(1) Defined the problem in terms of: (a) Background, (b) problem statement, (c) significance, (d) purpose, (e) rationale, (f) questions/hypothesis, (g) assumptions, (h) scope and limitations, and (i) terminology.

(2) Reviewed the pertinent literature, using the following library aids: (a) The card catalog file, (b) cumulative index to nursing and allied health literature, (c) social science index, (d) humanities index, (e) newspaper index, and (f) reader's guide to periodical literature.

(3) Prepared a descriptive research design:

(a) Contacted, either in person or by telephone, to determine the scope of the problem: (1) Police departments; (2) hospital administrators; (3) senior citizens groups; (4) adult protective services, Maine; (5) legislative search librarian, Maine and New Hampshire; (6) hotline/crisis intervention systems; (7) related social service agencies; (8) other home health agencies; (9) departments of welfare; (10) legal aid associations; and (11) physicians.

(b) Summarized findings and suggestions of contacts.

(c) Prepared a preliminary questionnaire from the review of the literature and assessment of the problem by contacts and researchers.

(d) Prepared a cover letter explaining the goal of the study.

(e) Formulated a tabulation design.

(f) Secured administrative approval and staff acceptance for the study at York County Health Services, Inc., and Portsmouth Community Health Services, Inc.

(g) Validated the comparability of the questionnaire with previous studies; agreement on questions reached by a jury composed of the researchers.

(h) Verified reliability of the questionnaire by a pilot test using supervisory personnel at PCHS and YCHS, plus nurses outside the agencies.

(i) Made necessary revisions in the questionnaire and tabulation design based on the report of the jury and pilot test.

(4) Gathered the data:

(a) Distributed the questionnaire to community health nurses and home health aides serving Portsmouth, New Hampshire and Biddeford-Saco, Maine.

(b) Collated returned raw data for tabulation.

(5) Analyzed and interpreted the data:

(a) Entered data on appropriate tables.

(b) Prepared graphs and figures, comparing results to previous studies.

(6) Summarized the study:

(a) Restated the problem, population, and design.

(b) Summarized results, indicating major findings.

(c) Related findings to the review of the literature.

(d) Indicated areas of weakness.

(7) Drew conclusions:

(a) Based on data.

(b) Related to study purpose, questions, and hypotheses.

(8) Made recommendations:

(a) For future use.

(b) For further study.

Chapter II

REVIEW OF RELATED LITERATURE

A search of the literature related to elderly abuse and neglect was made using the library resources at the University of Southern Maine, its interlibrary loan system, the library resources at the University of New Hampshire and its Gerontology Center, personal resources and the literature available at Portsmouth Community Health Services, Inc., York County Health Services, Inc., and the Division of Public Health Nursing, State of New Hampshire. In addition, a recent study of the problem of elderly abuse in Massachusetts was obtained. Both primary and secondary sources were used. Sources seemed to fall into four categories: Those which discussed abuse and neglect as a crisis aspect of or behavioral expression of situational stressors in family interrelationships; those which specifically addressed elderly abuse and neglect; these which presented case studies, often as news items; and those which discussed legal or official administrative practices relating to adult protection.

There were no sources found which denied elderly abuse and neglect as a health problem. There seemed to be general agreement among authors reviewed that too little is known about the problem. Most sources indicate a notion shared by the researchers that elderly abuse is a logical extension of awareness of child abuse and battered wife syndrome (Johnson, D., 1979; Lau and Kosberg, 1979; Pacific Stars and Stripes, 1979).

Kaplan and Cassel (1975) do not address the problem of family violence or elder abuse specifically. The study cited relates parent-child relationships to health-related behaviors. Significant for this study are the findings that "family characteristics * * * of perceived control or rejection * * * predispose adolescents to adopt coping behaviors which have long-term health effects which will manifest during adulthood * * * in socially prohibited modes * * * during times of stress and as a result of repeated episodes of stress" (page 17). Given that caring for an increasingly dependent parent involves repeated stress, one wonders whether the seeds of parent/elderly abuse are planted in the adolescent and that intervention should be directed to coping patterns in the family at all ages. Brady (1978) reinforces this thought in "that the elderly family member is the recipient of considerable assistance if strong, integrative relationships with other family members existed prior to the onset of illness" (page 557).

The "myth of abandonment" is laid to rest by Mindel (1979). This article, as does Brady's (1978) and Shanas (1979), documents substantial "kinship solidarity" remaining in the American family system, noting that only 5 percent of the U.S. elderly are institutionalized. Strong social norms for independence, the "nuclear family," small, efficient homes, and unusual family mobility do discourage, but not preclude, multigenerational living. Both authors cite the absence of funding support equal to institutional third-party reimbursement as evidence of an inconsistent public policy which fails to "visualize the elderly in the larger context of family, friends, and community" (Mindel, page 462).

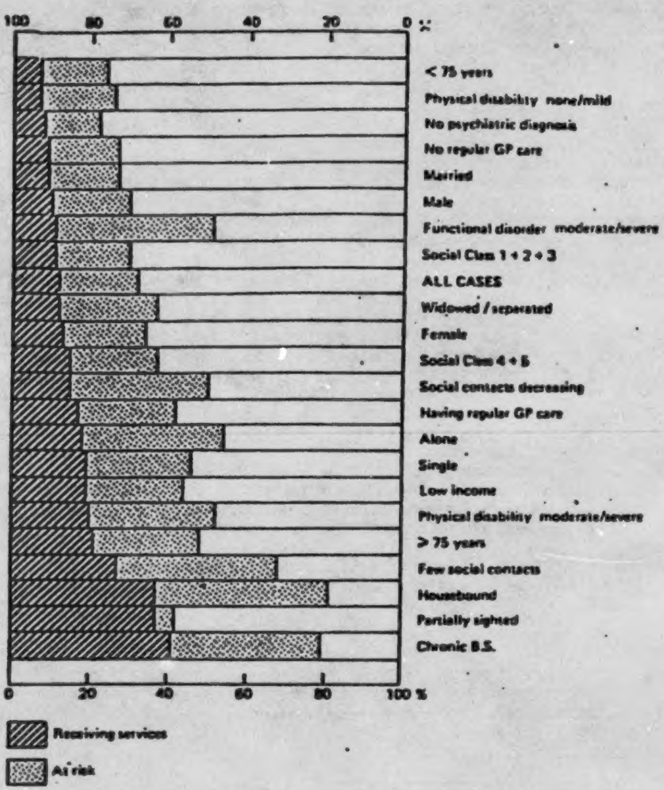
Kivett's (1979) article concerns itself with loneliness in the rural elderly. Significant for this study is the finding that rural elderly will accept extreme deprivation of food, sleep, and sexual fulfillment as well as endure a number of anxiety-arousing experiences, to avoid a sense of loneliness and social isolation. The catchment areas of Portsmouth Community Health Services, Inc., and York County Health Services, Inc., with a population density of 260 and 126 persons per square mile, respectively, are classified as rural, and the attachment to home and family is great.

In 1979 review of sociological studies, Shanas observes two important points for program planning for the elderly. The first is that "in 1975, three out of every four persons * * * over 60 * * * with children either lived in the same household as a child or within one-half hour's distance of a child" (page 6). The second point is that approximately "10 percent of old people * * * are * * * bedfast or housebound at home, just as in 1962 * * * and this is * * * almost twice the proportion of old people in institutions of all kinds" (page 8). The first point enlarges the proportion of elderly at risk for abuse by family members, for one-half hour's proximity may be nearly the same as multigenerational living, while the second point assists in delimiting the population at-risk further to an estimated 10 percent of those living with children.

Foster, Kay, and Bergmann report a study of the 65+ population in England. Their data, though not addressed to elderly abuse, support the successful family maintenance of disabled elderly at home who otherwise would require institutionalization. Of particular note, are the proportions of population at-risk and not receiving services. Since the mean age of the group studied was 76 years, this would indicate a real potential for abuse and neglect not located by the usual case-finding means in a country where out-of-pocket costs for in-home services are not a barrier. Ageism, or the stereotypical myth that one is supposed to feel less well as one grows older, often is a barrier to seeking health care when held by the elder and a deterrent to adequate and appropriate treatment when held by a provider.

Figure 4 illustrates the variables studied by Foster, Kay, and Bergmann:

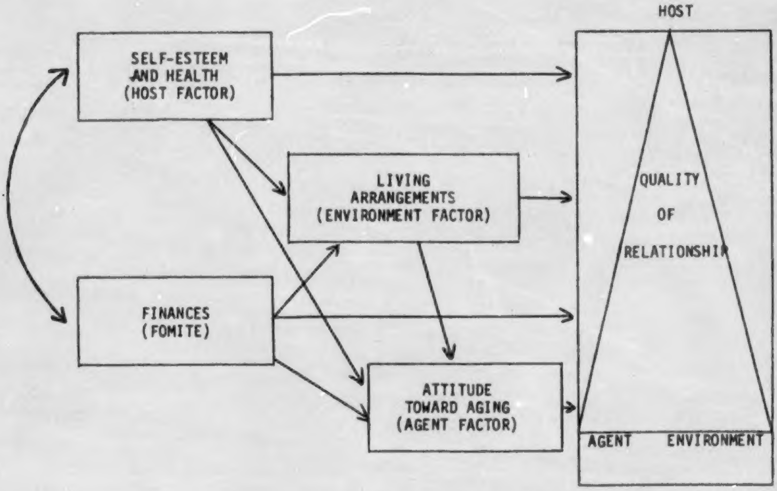
Figure 4.—Percentage of people with various characteristics receiving, needing or not requiring domiciliary service. (Foster, Kay, and Bergmann, 1976, p. 248.)



Hausman's (1979) article serves to produce both a profile of the stressors felt by adult children who accept care of an elderly, disabled parent as well as an example of a successful community support group facilitated by a Maryland community mental health center. The stressors examined included the role reversal, having to make a sudden, unexpected decision about having an elderly parent move in without time to plan or think about the degree of responsibility to be accepted, unresolved conflicts from childhood and adolescence, the burden of care and "feeling trapped" at a time of perceived independence from their own children, confrontation with and fear of their own potential morbidity and real mortality, anger, and resentment at siblings not involved in the parents' care, and communication gaps were listed. Interestingly, financial drain was not mentioned. The effective outcomes of the support modality in participants' comments tend to indicate its preventive value both for the elderly parent and the adult caretaker/child.

Finances are addressed by E. S. Johnson (1978), along with health, living environments, and morale, in her study of relationships between older mothers and daughters. The findings of Johnson and Bursk, that the quality of the relationship between the aged parent and adult child, correlated positively with the health of the parent, was upheld (page 304, and Johnson, D., 1979, page 11). The attitude of the adult daughter toward aging had the strongest correlation to the quality of the relationship, with living environment second. Perceived adequacy of health and finances affected both attitude and living arrangements. All are significant for intervention, whether indirect, as in anticipatory guidance, or direct, as in revised living arrangements, funding support, and health services or education. Johnson emphasizes that when income is inadequate, health poor, and living situation undesirable, aging parents may opt for multigenerational, dependent living even with children whose personalities have known incompatible patterns. "As a consequence, they may be forced to act compliantly with their children in order to preserve a relationship for which there are often no alternatives" (page 306). The interaction of host, agent, and environmental factors for elderly abuse or neglect, are then present as illustrated in figure 5.

FIGURE 5.—Adapted paradigm of host, agent, and environment interactional factors between older mothers and their adult daughters (Johnson, E. S., 1978, p. 303)


HOST
SELF-ESTEEM AND HEALTH (HOST FACTOR)
LIVING ARRANGEMENTS (ENVIRONMENT FACTOR)
FINANCES (FOMITE)
ATTITUDE TOWARD AGING (AGENT FACTOR)
QUALITY OF RELATIONSHIP
AGENT
ENVIRONMENT

A case study which took place in Lee, N.H. in 1978, is indicative of many of the variables that relate to elderly abuse. A 48-year-old son was found guilty of manslaughter, by beating, in the death of his 78-year-old mother. The son lived with his mother in a trailer. The mother was incontinent, unstable on her feet, and required personal care. The son displayed anger and resentment and, thus, resorted to violence. Health, living arrangements, and the quality of the relationship all contributed to this incidence.

Prof. Murray Straus, at the University of New Hampshire, has established a center to study the entire scope of beatings, neglect, and humiliations that are called family violence. He states "money talks, and anyone who says it does not, has never studied power in the family." Professor Straus is in the process of looking at communication patterns within the family and how they relate to family violence. Violence to whom and by whom can relate to the balance of power within the family, the solidarity of the family group, and the problem-solving strategies of the family.

Most sources dealing with legal or official administrative practice relating to adult protection, find there are defects in all the laws as well as in the way they are applied. Ferguson, E. J. (1978), states in her book "Protecting the Vulnerable Adult" that:

"Although States can act based on the legislative authorizations of their social welfare, mental health, and public health departments, the adult protective services literature frequently decries the lack of specific mandate to investigate, to offer assistance on repeated occasions, to intervene, and, if necessary, to petition courts for relevant remedies. A legislative mandate is needed to remove liability for parties reporting or assisting in good faith, to affix penalties for violations, to safeguard individual rights against inappropriate intervention, to make the assisting party accountable, and to provide a mandate to explore alternatives to institutionalization."

This clearly indicates that legislative reform is needed.

Both Wasser, E. and Regan, J. J., state that intervention, without authority is an issue that must be dealt with from the legal standpoint so that protective service programs can be implemented. Responsibility and self-determination, on the part of the social worker, will only occur when the social worker has the power to act.

Kaby (1974) comments on the results of a 3-year demonstration project on "Protective Services to Older Adults," which was conducted in Washington, D.C., that "Washington is one of the few States that has the courage to claim it provides this service." We, in other States, need to ask ourselves, "Why?"

Maine law and the administrative policies of Adult Protective Services, appear to limit their application to victims of elderly abuse or neglect. Chapter 578 of Maine Public Law, enacted into law without the Governor's signature, specifically calls assault between members of the same household a crme, but most of its language is about spouse or former spouse. Parent-child relationships are not addressed (1980). Chapter 565 (1979) mandates the Department of Human Services to provide emergency shelter, counseling, and coordination during a "serious threat of violence or other serious family crisis." It is specifically short-term and with a relatively small appropriation ($100,000). Adult Protective Services policy speaks to supportive services only for "incapacitated adults for whom there is no other recourse."

Supportive services include "counseling, transportation, assistance in obtaining adequate housing, medical or psychiatric care, and nutritional services." Clearly, neither the gamut of services nor the language of the law is adequate to have significant impact on the problem of abuse and neglect in the disabled elderly population.

In 1979, New Hampshire passed two laws relating to reporting of adult abuse and to protective services to adults, chapter 357, HB237, and chapter 372, HB738, respectively. These laws became effective on August 22, 1979. At the same time, chapter 395, HB88, was enacted which established the office of ombudsman within the State council on aging and appropriated funds for this position. Due to the complexity of the State system, these laws have not as yet been put into practice. Formal training sessions for social workers have been completed and one can hope that changes will begin to take place based on these laws. Chapter 357 provides immunity from liability for reporting, investigation within 3 days of reporting, establishment of a State registry and a penalty for violation. Chapter 372 provides access to premises by court order and court-ordered examinations. With the current shortage of social workers in the State of New Hampshire, and the mechanism, or lack of, utilized by the State in making these laws known to the public, it is difficult to imagine any great changes in addressing this problem taking place.

In 1978, Connecticut enacted laws based on utilization of title XX funds providing for protective services for the elderly. Massachusetts, at this time, enacted laws providing for protective services including temporary protection.

All of these laws can be useful but provide only minimal protection because of their weak enforcement provisions. The process in all States appears to be cumbersome and fails to address the need for immediate protection and utilization of supportive services.

The Massachusetts study completed in 1979, is one of the more extensive available at this time. The findings in this study are fairly consistent with other findings citing such variables as dependency, living arrangements, stability of early family life, and stress.

All readings indicate we have a long way to go toward understanding the dynamics of family violence in general and elder abuse in particular.

Chapter III

DESIGN OF THE STUDY

A descriptive research design utilizing an exploratory survey composed of interviews and a questionnaire was chosen in order to gain insight into the problem of elderly abuse and neglect. During the search phase of our study, an interview was conducted on a population believed to be restricted to those who were able to make a significant contribution to the investigation. New Hampshire and Maine statewide health and social service personnel were selected because of their contact with the elderly population and likelihood of seeing and or treating abuse and neglect. The nature of the study was explained and an unstructured interview composed of questions regarding the existence, scope, frequency, treatment, and referral of the problem was administered.

Findings were summarized, a cover letter explaining the nature of the study was prepared and a preliminary questionnaire was devised using, as a guide, the questionnaire from the study "Elder Abuse in Massachusetts" (June 1979). The questions were structured in hopes of ascertaining the following variables associated with elderly abuse and neglect: Problem recognition; prevalence; causes; and time, person, and place dynamics. Content validity of the questionnaire was achieved by having a jury composed of the researchers judge a question's relevance for inclusion. Reliability was verified by giving the questionnaire as a pilot test to supervisory personnel at Portsmouth Community Health Services and York County Health Services, and to nurses outside these agencies.

It was felt that the phenomena of elderly abuse and neglect could best be described by questioning those who were likely to view it in its natural setting, the home. Thus, the questionnaire was distributed to community health nurses and home health aides serving Portsmouth, N.H., and Biddeford-Saco, Maine. Respondents were asked to recollect, during the past 18 months, cases of elderly abuse and neglect that coincided with the study's definition of the problem and complete one questionnaire per case. Prior administrative approval and staff acceptance was obtained at these two agencies. All inquiries, as to the meaning or wording of the questions, were handled by the researcher who administered the questionnaire.

The respondents to the questionnaire were anonymous as to name but did include staff positions and agency. Thus, survey results could be verified. In the decision to use a convenience sample of readily available peers of the researchers, the survey was not planned to yield an unduplicated or precise count. Instead, the recall of professional and experienced community health agency staff was anticipated to reveal sufficiently accurate data to meet the purpose of this study.

In the second phase of the study, a questionnaire was distributed to community health nurses serving Portsmouth, N.H., and Biddeford-Saco, Maine. In order that the results could be considered statistically significant, a table for determining sample size was consulted. The fiscal year 1980 caseload over age 65 years for the Biddeford-Saco area, or 343 individuals, exceeded the sample size 4,217 needed to be representative of the entire caseload. The 65+ caseload for Portsmouth was 298, also in excess of the necessary sample size of 197. However, sample sizes required to to draw conclusions from the 65+ populations are slightly small; Portsmouth has 3,304 people 65+, requiring a sample of 343, but the 65+ caseload was 298. Likewise, the Biddeford-Saco 65+ population is 4,034, while the 65+ caseload was 343, slightly under the needed sample of 351. For the purpose of a descriptive study and since the population data available is mathematically estimated from the 1970 census, the samples seem sufficient, though generalizations cannot be made with certainty. Additional justification for the "goodness" of available sample size is that 5 percent of the 65+ population are institutionalized according to national norms, so the 65+ population base are not all at home or candidates for home care caseload.

TABLE 2.—Determination of sample size[1]

Geog. Area	Total Pop.	R/S	Pop. 65+	R/S	Agency	FY 79-80 Caseload	R/S	FY 79-80 65+Cald.	R/S
Portsmouth	23,600	377	3304	343	PCHS (Portsmouth)	413	197	298	168
Bidd-Saco	32,700	379	4034	351	YCHS (Biddeford-Saco)	572	217	343	222

R/S=required sample size.

[1] Table for Determining Sample Size from a Given Population, "Educational and Psychological Measurement."

Chapter IV

PRESENTATION AND ANALYSIS OF THE DATA

To determine what was known about the prevalence of elderly abuse or neglect, and also what resources are available to address the problem, a variety of officials and agencies assumed to be interested, were contacted.

Edward McGeachey III, M.S.W. and assistant executive director, Webber Hospital Association, Biddeford, Maine, checked emergency room and inpatient diagnostic data since July 1, 1978, without revealing any cases of suspected elderly abuse. He did report, however, that the emergency room head nurse and social service department staff were apologetic about "not looking for evidence of elderly abuse," equating the lack of awareness to "child abuse 15 years ago." Mr. McGeachey also indicated a weakness in the hospital automated data system; elderly abuse is not a coded category for primary or secondary admitting diagnosis. He communicated an interest in this study and suspicion among hospital personnel that some cases had existed in recent months.

Lawrence Gross, project director for Southern Maine Senior Citizens, Inc., stated that he could think of no cases of physical abuse over the preceding 18 months, but immediately called to mind four to five cases he would have termed neglect. All of these were referred either to Maine Adult Protective Services "for boarding home placement," York County Health Services "for skilled home health care," or homemaker services. Elderly abuse and neglect was expressed as "a concern related to our general advocacy program."

Lester Bennett, supervisor, region I (southern Maine) Adult Protective Services, stated that the current administrative policy (State of Maine, 1975) of the Department of Human Services was very restrictive. Statistics on cases referred because of abuse are not kept; neglect or abandonment were common reasons for referral. Individual caseworkers determine the degree of need for continuing monitoring of neglect situations and only two caseworkers are available for York and Cumberland Counties (ratio of 1 to every 168,712 persons). A medical statement testifying that "afflictions, not possible by accident and resulting from the actions/inactions of an identified person," together with photographs, are required by Maine courts to prove criminal abuse or neglect, and these "are almost impossible to get." The Adult Protective Services unit encourages remaining at home "because of the shortage of nursing home beds" and "need to contain medicaid spending," so referrals to local agencies are made. Petitions to the court for guardianship, are made in life-threatening situations, and public guardianship is the last resort. Mr. Bennett could recollect one example in the past 2½ years. He stated his personal belief in the need to study the problem further and hopes that public policy will eventually change so he "has sufficient staff to address it properly." He also believes that mandatory reporting of elderly abuse will be necessary for public recognition and funding support to resolve the problem.

Both Biddeford and Saco police officers could not recall any case of elderly abuse or neglect in the past 2 to 3 years. Their calls are not kept in any meaningful statistical way to use for this study. "Domestic disturbances" and "assault" were two possibilities, but no ready-way existed to retrieve records. It seemed significant to note that it took more prompting to effect understanding of the problem by the police; the initial perception was more "mugging" or "assault" on elderly by unrelated individuals. The deputy chief revealed what may prove a common attitude: "I think old people would be too ashamed to complain about abuse by a relative."

Mrs. Czerwinski, a staff member of Caring Unlimited, a nonprofit organization which provides temporary shelter for battered women and abused adolescent children, stated that she was certain "elderly/parent abuse was a problem" in the Biddeford-Saco, Maine, area. She cited one case of battering of an elderly debilitated wife by her husband and son. Mrs. Czerwinski believes that if the problem were better defined, more cases would be reported. She cited "embarrassment, shame, and fear of placement in a nursing home" as barriers to reporting elderly abuse even by neighbors. She also suggested alcohol abuse as a related problem "to all family violence."

Ann O'Neil, adult health clinic coordinator at York County Health Services, stated she had never been able to confirm several instances where she has suspected abuse and neglect among the ambulatory adult population who utilize clinics. She shared particular concern for residents in two local boarding homes and has reported one to the Department of Human Services, Division of Licensing and Certification. Investigation is now underway. Indepth assessment is provided where bruises, welts, and unusual posture or gait are noted. The adult health clinic saw more than 2,500 persons, over 60 years of age, during fiscal year 1979. Approximately 1,230 of these persons were from the Biddeford-Saco, Maine, area (York County Health Services. 1979).

Beverly Tirrell, executive director of South Portland Health Services, stated that a common form of elderly abuse in her agency's area, is financial/material abuse (the withholding of funds by guardians/caretakers). Ms. Tirrell believes that many families keep their elderly members at home in order to receive the social security check and that the elderly are so afraid of "being placed" that they refuse the release of information via the community health nurse to complain.

Phyllis Gray, elderly advocate supervisor for Southern Maine Senior Citizens in York County, cited at least six cases of elderly abuse and neglect over the past 18 months. Her particular concern was neglect resulting from inattention by a legally appointed conservator or guardian. She believes that restructuring of Maine Adult Protective Services, and mandatory reporting, is a prerequisite to resolving the problem.

Ann Thibodeau, social gerontologist, Pine Tree Legal Assistance, states that the majority of their cases were battered women and 5 percent of those were over 60 years old. She continued to say that most were referred by a community agency, usually housing services. More definite data was not available.

Mary Ann Peters, nursing director of Wentworth Douglass Hospital, Dover, N.H., indicated that elderly abuse is not a coded category for admitting diagnoses. She felt that the hospital emergency room saw from 10 to 12 cases of elderly neglect during 1979, out of approximately 7,200 admissions. Neglect was classified as bed sores, malnutrition, poor hygiene, and deformities (from not being moved and turned). There seemed to be no incidence of battered elderly.

David, a social worker for Concord, N.H., Info-Line (information and referral), also had no coded category for elderly abuse and neglect but cited 10 cases in the past year out of about 6,000 calls. Half of those 10 calls were from the victims themselves and the other half were from neighbors. The problems mentioned concerned financial abuse of the elderly's income by a relative. Callers were referred to the Division of Welfare and Legal Assistance.

A social worker from the Newmarket, N.H., Info-Center, recalled only 1 call during the past 9 months out of approximately 6,000 calls. An aide suspected a husband of abusing his elderly, incapacitated wife. The caller was referred to the Division of Welfare.

Cecile Gagne, from the administrative staff of Strafford County Homemaker-Home Health Aide Association, explained that 6 cases of elderly abuse were found by aides last year, out of 450 people seen. One client was placed in a nursing home after being physically abused. Five cases concerned financial abuse and the aides were able to handle this by dealing with other members of the client's family.

Connie Theberge, a nurse in a Dover, N.H., physician's office, mentioned 5 or 6 cases of elderly physical and emotional abuse during the past year, out of 5,000 clients seen. Many of the victims were ashamed to discuss the situation. Some were placed in a nursing home or with other family members. In the other cases, the physician talked with family members about the problem. Many of the victims did not want to be removed from the setting.

Laurie Jackson, a nurse from the Tri-Area Visiting Nurse Association in Somersworth, N.H., felt that there had been one or two cases of elderly abuse among their caseload during the past year. One case was verbal abuse by a husband to his chronically ill wife. The VNA was trying to obtain support from other family members so the husband could have some free time away. Another elderly client was incapacitated and left alone periodically by family members. A robber entered the house but the victim, who is blind and deaf, was unaware of his presence. Now the family locks the house when they leave and the VNA fears the client will be trapped in the event of a fire.

Suzanne Griffith, nursing director of Oyster River Home Health Association in Durham, N.H., which serves a population of 10,000, cited one case of elderly physical abuse by the client's daughter. The VNA referred the case to the Division of Welfare.

Chief Reynolds of the Dover Police Department could think of no cases of elderly abuse and neglect that were handled by his department. The police coding system is not broken down into age and abuse would come under the category of domestic violence which mostly consists of assault.

Susan Karmeris, a nurse from the Division of Public Health, informed us that she had just attended an inservice concerning elderly abuse and neglect given by the Division of Welfare. The problem was just beginning to gain recognition and statistics were being compiled.

Gail Bell, a social worker from the Division of Welfare, gave us information concerning the new laws on elderly abuse and neglect and the role of the Division of Welfare. She also distributed the inservice materials that were given to health and social service agencies so they could be alerted to the problem. Although no formal statistics were available, yet, Mrs. Bell felt there were five referrals last month from the Strafford County population.

Murray Straus, Ph.D. and professor of sociology at the University of New Hampshire, was contacted about his research on "Violence in the Family." He explained that his study dealt with abused children and middle-aged parents.

The New England Gerontology Center in Durham, N.H. was contacted. They have received no referrals but offered library resources dealing with elderly abuse and neglect.

Thomas Dunham, M.D., chief of emergency services at Portsmouth Hospital, stated that he had not observed any evidence of elderly abuse or neglect but neither had he been aware of the potential problem so, thus, had not looked for it.

The charge nurse in the emergency room at Portsmouth Hospital had noted several instances in the past few months when she questioned the possibility of abuse. She did not, however, pursue the issue but does feel it is a serious problem that they should be more cognizant of. Both Doctor Dunham and the charge nurse were very interested in pursuing this subject further.

Dorothea Reed, director of Community Council of Senior Citizens in Portsmouth, N.H., has been interested in this problem for the past year. Through her organization, many calls have been received from individuals unable to cope with caring for the elderly in their home and have expressed a need for a support system. To meet this need, a community group of service agencies formed a task force and sponsored three sessions on "Elderly Children Caring for Elderly Parents". Mrs. Reed is in the process of developing this further.

Lee Ballard, Director of Area Homemaker-Home Health Aide Services in Portsmouth, N.H., states this problem as being one of the most difficult her organization has had to deal with. Over the past 18 months, her homemakers have reported, to her, more than a dozen cases of suspected and/or actual abuse and neglect. They have found the legal system very ineffective and families themselves, unwilling or unable to discuss the problem, Mrs. Ballard feels there is a great deal to be done in this area.

Lois Kilroy, R.N., a supervisory nurse at a local extended care facility, notes that families that neglect the elderly in nursing homes, do so more out of shame which stems from lack of understanding than from any other cause. Ms. Kilroy firmly believes that nursing homes must play a greater role in working with families, a family that includes the elderly individual as part of the family unit.

Susan Turner, a legal aide with the New Hampshire Legal Aid Association, has been working very closely with the New Hampshire Division of Welfare

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as an "elderly client advocate." Ms. Turner feels the legal aspects of this problem have not yet been recognized and that elderly individuals are constantly being denied their rights as human beings. The 1980's will be the era for awakening the public to this problem.

Betty Burtt, R.N., director of Public Health Nursing for the State of New Hampshire, Department of Public Health, is currently involved with one of her public health nurses and a local physician on an elderly abuse case. The physician refuses to acknowledge the abuse which presents a barrier to resolution of the problem. Ms. Burtt is interested in working with the State on solutions to this problem.

Nancy Boyle, R.N., director of the Dover Visiting Nurses Association, Dover, N.H., had her first documented case of abuse 6 months ago. In this case, the physician also refused to recognize the problem and discharged the VNA and had the family hire private duty nurses. To the best of her knowledge, Ms. Boyle states that the problem still exists due to the fact that the private duty nurses are caring for the patient only on an intermittent basis.

The consensus of opinion of all interviewed is that elderly abuse and neglect is a potentially serious problem and one that has not received the attention that it warrants. Understanding of the problem and approaches to dealing with it, are only in the beginning stages of development. Society is only now recognizing and acknowledging that it does exist and with a thorough analysis of the problem, the possible solutions will be identified. Social services agencies, Federal, State, and local government, consumers and all involved in working with the elderly, are necessary links in the coordinated system needed to address this problem.

Table 3 displays the Maine and New Hampshire statewide health and social service agencies that were interviewed and whether they were aware or unaware of the problem of elderly abuse and neglect in their catchment area. The number of abuse citings and referrals is listed for those aware of the problem. Some sources were contacted to specifically provide educational material concerning the problem.

Table 3

New Hampshire and Maine Professions Seeing Abuse

Profession	Unaware	Aware	Abuse Citings	Referral	Educational Resources
Hospital Emergency Room					
Portsmouth, N.H.		x	1		
Dover, N.H.		x	10-12 1979 per 7200 admissions		
Biddeford, Me.	x				
Extended Care Facility		x	several questionable		
Visiting Nurse					
Dover, N.H.		x	2	1	
Somersworth, N.H		x	2		
Durham, N.H.		x	1	1	
Portland, Me.		x	financial common		
N.H. Division of Public Health Nursing		x	1	1	x
N.H. Physician		x	5-6 1979 per 5000 office visits	2	
Division of Welfare					
N.H.		x	5 in Feb. 1980 per 81,395 pop.	5	x
Me.		x	1	1	
N.H. Legal Aid		x	several questionable		
Police					
Portsmouth, N.H.	x				
Dover, N.H.	x				
Biddeford, Me.	x				
Saco, Me.	x				
Home Health Aide					
Portsmouth, N.H.		x	Many		
Dover, N.H.		x	6-1979 per 450 clients		
Senior Citizens					
Portsmouth, N.H.		x	several		
Southern Me.		x	4 - 5		
Me. Shelter for Battered		x	1		
Info Line					
Concord, N.H.		x	10 in 1979 per 6,000 calls	10	
Newmarket, N.H.		x	1 in 1979 per 6,000 calls	1	
New England Gerontology Center, Durahm, N.H.		x			x
University of N.H. Sociology Dept.		x			x

Taken from interviews by the researchers of statewide professions in N.H. and Maine.

The results of the interview and table seemed to reveal that there was some awareness of elderly abuse and neglect but it was not uniformly defined, acknowledge, or referred. Many agencies did not have a diagnostic or category coding for this problem, and thus there was little statistical information yielding incidence and prevalence other than the recollections of staff members.

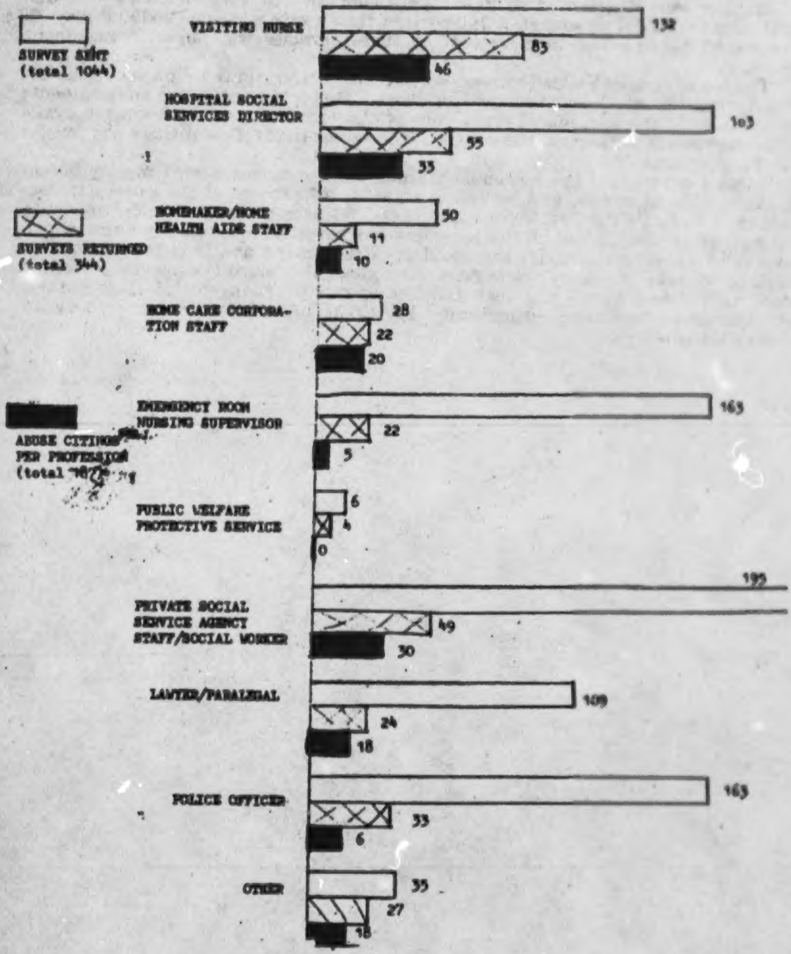
The agencies that were aware of abuse and either dealt with it or referred it may serve as target agencies for coordinating a uniform referral and followup system so that there is continuity of care and prevention of overload to any one agency.

It was interesting to note that the police did not recognize any cases of elderly abuse. Because of the availability of the police and no direct fee for service, they may be a potentially good resource for dealing with the problem and linking abused clients to other referral sources.

Figure 6 displays a bar graph showing statewide Massachusetts professionals seeing elderly abuse. This was taken from the statistics of a 1979 study on "Elderly Abuse" in Massachusetts (O'Malley, 1979, page 11). The police in this study also seemed to have a low citing of abuse for the number of surveys that were sent out. Massachusetts visiting nurse and homemaker health aide associations also seemed to be good resources for dealing with abuse as was found from our interviews and questionnaires.

In the Massachusetts study the category "other" comprised nurses, medical social workers, probation officers, and other persons who primarily provide services to the elderly. There was also a category "no answer" for profession in which 7 surveys were returned with one abuse citing (O'Malley, 1979, page 1, 12).

FIGURE 6 MASSACHUSETTS PROFESSIONS SEEING ABUSE



The questionnaire that was administered at PCHS and YCHS contained a definition of elderly abuse and a request for one case per questionnaire, 36 questionnaires were distributed to PCHS personnel, and 15 questionnaires were distributed to YCHS personnel. A 100 percent return rate was achieved and may be explained because the investigators at these agrncies were in a management position.

The questionnaire yielded responses designed to ascertain to following variables: Characteristics of the abused person (host), abuser (agent), and environment; dynamics of time and place; prevalence of the problem; causes; resources available; barriers to action; and resolution. The tables that follow display the results of the questionnaire.

Table 4 shows that the respondents from the two agencies were mainly homemakers, visiting nurses, and home health aides, 47 percent of the questionnaires returned from PCHS had abuse citings, and 80 percent from YCHS had abuse citings. More than half of all the questionnaires returned cited elderly abuse which means in these two agencies the problem is recognised and it is prevalent. The high prevalence of elderly abuse cited may mean that since the agency personnel deal with clients (host) and their families or caregivers (agent) in their natural environment—the home—community health agencies may be more likely to detect the problem.

Table 4

Respondents Position and Number of Surveys Returned with or without Abuse Cited.

	Visiting		P.T.*	Home Maker	Home Health Aid	Abuse Citings		Total surveys returned for agency
	RN	LPN				yes	no	
PCHS	5		1	23	7	17	19	36
YCHS	13	1			1	12	3	15
Total	18	1	1	23	8	29	22	51

Taken from PCHS and YCHS survey responses. *Physical therapist

Table 5 depicts the age distribution of abused persons by PCHS and YCHS with the age distribution of the general population. The lower general population distribution in the 75+ category seems to validate the present investigators finding of increased abuse occuring in the very old (75+). This corresponds with the review of the literature findings.

Table 5

Summary of Age Distribution of Abused Persons Compared with Age Distribution of General Population.

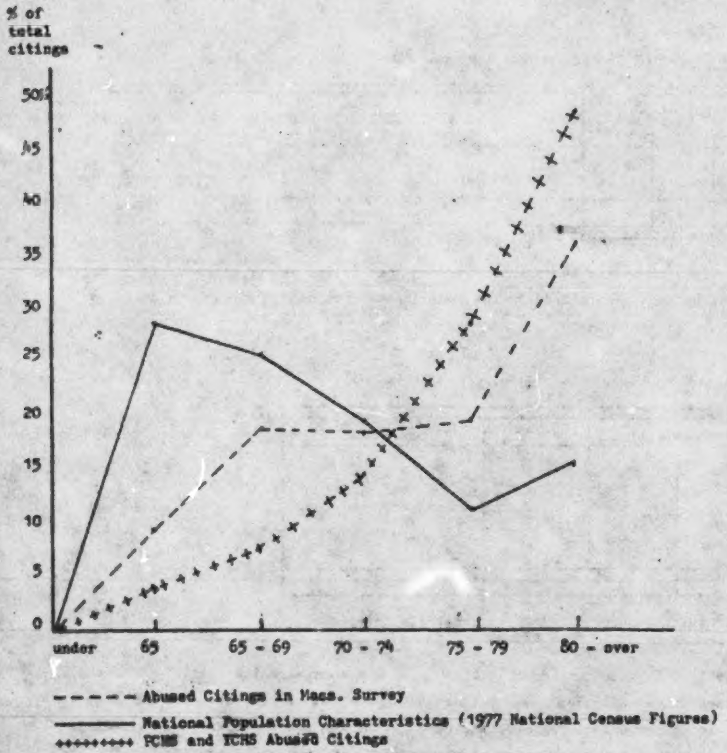
Age	# citings		Total Citings	% of total citings N=29	National Population x 1000	% of total Population
	PCHS	TCHS				
under 65	1		1	3%	9362	28%
65 - 69	2		2	7%	8446	26%
70 - 74	2	2	4	14%	6137	19%
75 - 79	2	6	8	28%	4068	12%
80 - over	10	4	14	48%	4842	15%
Total	17	12	29	100%	32855	100%

National Population 1977 Census Report taken from Elder Abuse in Massachusetts. (O'Malley, 1979, p.23) Also taken from PCHS and TCHS survey responses.

Figure 7, a frequency polygon, compares the proportion of abuse citings from PCHS and TCHS with Massachusetts and with National population characteristics. (O'Malley, 1979, p. 20). The Massachusetts study's abuse citings has the same upward trend of citings age 75+ as the findings from PCHS and TCHS.

Figure 7

Comparison of the Proportion of Abuse Citings Within Each Age Group in Mass., N.H., and Maine Surveys with the Proportion of National Population in Each Age Group.



Taken from Elder Abuse in Massachusetts (O'Malley, 1979, p.20) and PCHS and YHCS survey responses.

Table 6 indicates that 72% of the abused persons cited by PCHS and YCHS were female. This seems to correspond to the literature and 58% of the national population is female. However, PCHS could have had a larger female population than male. YCHS was half female and male. There are more females in the national population 75+ than males.

Table 6

Summary of Sex of Abused Persons Compared with General Population.

Sex	# Citings PCHS	# Citings YCHS	Total Citings	% of Total Citings N=29	National Population	% of Total Population
Female	15	6	21	72%	18,906	58%
Male	2	6	8	28%	13,950	42%
Total	17	12	29	100%	32,855	100%

Taken from PCHS and YCHS survey responses.

Table 7 shows the age of caregiver in home of the abused person. It seems that there is usually a caregiver in the home and that person is elderly as noted by PCHS and YCHS respondents.

Table 7

Summary Age of Caregiver in Home

Age	PCHS	YCHS	Total
10 - 14		1	1
20 - 39	2	2	4
40 - 49	4	2	6
50 - 59	1	2	3
60 - over	8	6	14
none	2	2	4
Total	17	15	32*

* Indicates respondents identified multiple caregivers. Taken from PCHS and YCHS survey responses.

Table 8 illustrates the relationship of the abuser to the victim. PCHS and YCHS identified multiple abusers but son, daughter, other relative, and husband seemed to be the main categories indicating that the abuser is within the family. It may seem that the elderly abused person requires care and therefore has to live with or depend on family members.

Table 8

Summary of Relationship of Abuser to Victim

Relation	#		Total citings	Citings N=29
	FCHS	YCHS		
Husband	4	2	6	21%
Wife		1	1	3%
Son	6	2	8	28%
Daughter	5	3	8	28%
Son in law		1	1	3%
Daughter in law	1	2	3	10%
Other relative	3	5	8	28%
Non - relative				
Total	19	16	35*	121%*

*Indicates that respondents identified multiple abusers.

Taken from FCHS and YCHS survey responses.

Table 9 exhibits the situational stresses of the abuser, victim, and family. FCHS and YCHS respondents noted that the abuser seemed to be experiencing the following: resentment over loss of independence (10 citings); alchohol/drug problems (9); long term financial problems (7); and limited education (7). The victims' stresses were: long term medical complaint (13); long term financial problem; and limited education. The family was experiencing the stress of a long term medical complaint. Multiple categories were checked and from the replies it seems that stress is a factor in situations where abuse occurredin the populations covered by FCHS and YCHS.

Table 9

Summary of Stresses

Stress	PCHS			YCHS			Total		
	abuser	victim	family	abuser	victim	family	abuser	victim	family
Alcohol/drugs	4	1		5		3	9	1	3
Long term Medical complaint	1	8		2	5	6	3	13	6
Recent loss of spouse through death or divorce		2						2	
Recent birth of a child									
Recent death in immediate family									
Past suicide attempt					1			1	
Long term financial problem	4	4		3	4	5	7	8	5
Recent financial problems other than loss of job	1	1	1		2		1	3	1
Recent loss of job	1		1		1		1	1	1
Limited education	3	2		4	5	3	7	7	3
History of mental illness	4	2		1	1	1	4	3	1
Lack of needed services	1	3	2	3	3	2	4	6	4
Resentment over loss of independence	5	3		5	3	1	10	6	1
Legal problems	2	1		3	1	1	5	2	1
Other	3	2	2				3	2	2
Total	28	29	6	26	26	22	54*	55*	28*

* Indicates that respondents checked more than one category.
Taken from PCHS and YCHS survey responses.

Table 10 shows the incidence of violence or abuse within the immediate family of the abuser. 69% of PCHS and YCHS had no and 31% had yes, listing citings of child abuse, spouse abuse, and other. More research would have to be done to make any interpretations.

Table 10

Other Incidence of Violence or Abuse Within the Immediate Family of the Abuser

Responses	PCHS #	YCHS #	Total	% of Total citings N=29
Yes	2	7	9	31%
child abuse		2	2	
spouse abuse	1	2	3	
assault/battery				
other	1	3	3	
No	15	5	20	69%
Total	17	12	29	100%

Taken from PCHS and YCHS survey responses.

Table 11 displays the victim having a disability which prevents him/her from meeting daily needs. PCHS and YCHS had yes 86% and no 14%. It seems that this factor might add to the stress of the situation and along with the results of table 8 verify that the abused person requires care and therefore has to depend on family.

Table 11

Summary of Occurence of Abused Persons Having Mental or Physical Disability which Prevents Him/Her from Meeting Daily Needs

Disability	# PCHS	# YCHS	Total	% of Total citings N=29
Yes	13	12	25	86%
No	4		4	14%
Total	17	12	29	100%

Taken from PCHS and YCHS survey responses

Table 12 depicts the occurence of the abused person living with others. It seems from the results of PCHS and YCHS that there is a tendency for the victim to live with others (59%) than not (41%).

Table 12

Summary of the Occurence of the Abused Person Living with Others

Responses	# PCHS	# YCHS	Total	% of Total citings N=29
Yes	7	10	17	59%
No	10	2	12	41%
Total	17	12	29	100%

Taken from PCHS and YCHS survey responses.

Table 13 shows the occurence of the abuser living with the victim. 72% of PCHS and YCHS respondents said yes and 28% said no. Thus from the replies of these two agencies it seems that this table along with table 8 and 11 verify the following: the abuser is within the family of the victim; the abuser usually lives with the victim; and the victim usually has a disability and needs help with daily needs.

Table 13

Summary of the Occurence of Abuser Living with the Victim

Responses	# PCHS	# YCHS	Total	% of Total citings N=29
Yes	11	10	21	72%
No	6	2	8	28%
Total	17	12	29	100%

Taken from PCHS and YCHS survey responses.

Table 14 exhibits respondents' intervention. PCHS and YCHS responded that more than one type of action had been taken. In 62% of the citings some form of direct action was taken. This corresponds exactly with the 1979 Massachusetts study. 14% of the questionnaires stated that emergency action was taken and 48% of the questionnaires indicated that a referral was made. 48% is also the percentage cited in the Massachusetts study under referral category. (O'Malley, 1979, p.37).

The direct action most cited was "arranged or increased in-home services". The remarks from PCHS and YCHS questionnaires seemed to indicate that this meant initiating or increasing visiting nurse and or homemaker home health aide visits to the victim. The next category most cited by the respondents under direct action was "conference with physician" and "spoke with/counselled abuser". Under emergency action "medical treatment or hospitalisation" and " boarding home placement" was most cited. "police" was only cited once.

Referral action most cited was "viciting nurse" who usually supervises the home health aides and works with the homemakers. The next category cited most under referral action was "homemaker home health aide" which usually meant the reporting of abuse to the homemaker's or aide's supervisor. "Welfare" was next cited.

A most interesting feature of these findings is that when abuse was cited, PCHS and YCHS personnel seemed to try and keep the victim in familiar surroundings unless emergency placement was needed. The respondents also seemed to aide the situation by the following: increasing supportive services; alerting supervisory personnel in their agencies and the phycisian to the problem; and counselling the abuser. This may be interpreted as coordinating a team approach to deal with the problem. It was noted that a variety of referral sources were used.

Table 14

Respondents Intervention

Action taken	PCHS	YCHS	Total	% Total surveyed N=29
Direct action.	8	10	18	62%
none	2		2	
placement/hospitalization	1	1	2	
arranged or increased in-home services	6	2	8	
inter-agency response	1	2	3	
spoke with/counselled abuser	1	3	4	
spoke with/counselled abused		1	1	
spoke with/counselled family	2	1	3	
conference with physician	2	2	4	
Emergency action		4	4	14%
medical treatment or hospitalization		2	2	
boarding home placement		2	2	
police		1	1	
nursing home placement				
Referral action	11	3	14	48%
hospital social service		1	1	
visiting nurse	6	1	7	
homemaker home health aide	4		4	
legal services		1	1	
hospital		1	1	
physician	1		1	
police		3	3	
welfare	1	3	4	

Respondents checked multiple types of action so percentages do not add to 100% and totals are eliminated.

Taken from PCHS and YCHS survey responses.

Table 15 displays barriers that were encountered during intervention. The one most cited by PCHS and YCHS was the category "family's/abuser's lack of cooperation". The category "other" was next most cited and included no proof and no food. Also in the "other" category was abuser never present when respondent was, so could not be confronted with the problem, and a victim living alone was unable to do self care.

Table 15

Barriers to Intervention

Responses	# PCHS	YCHS	Total
o barriers cited	9	2	11
esponses citing barrier	8	10	18
caregiver inadequate		2	2
refusal of services by abused		1	1
financial		2	2
family's/abuser's lack of cooperation	2	6	8
lack of services		1	1
access refused	2		2
bad living condition		1	1
other	3	1	4

Respondents checked multiple types of barriers. Percentages and bottom totals are eliminated. Taken from PCHS and YCHS survey responses.

Table 16 represents resolution of the "problem". 79% of the PCHS and YCHS respondents stated the problem was resolved although 14% or in 4 instances, the victim died. It was not stated if the victim died of abuse, illness, or old age. 21% of the respondents indicated the problem had not been resolved. Not much more can be said about the actual status of the abuse situation from this data.

Table 16

Problem Resolution

Response	# PCHS	YCHS	Total	% of total citings N=29
Yes	12	11	23	79%
(victim died)	(2)	(2)	(4)	(14%)
No	5	1	6	21%
Total	17	12	29	100%

Taken from PCHS and YCHS survey responses.

Table 17 reveals time in which the abuse occured. It seems that respondents from PCHS indicated that abuse did not occur at any special time. YCHS respondents 6 p.m. - 12 midnight and fall (4 citings) was when most of the abuse took place.

Table 17

Time in Which Abuse Occurred

Time	% PCHS	% YCHS	Total
Time of day			
6 am to 12 noon	3		3
12 noon to 4 pm	2		2
4 pm to 6 pm	3	1	4
6 pm to 12 midnight	2	4	6
12 midnight to 6 am	2	1	3
Time of year			
spring	3	2	5
summer	1	2	3
fall	1	4	5
winter	2	3	5
Daily	2		2
Continual	2	1	3
No special time	2	2	4
Unknown	1	2	3
Before pay day	1		1
After pay day or time of social security check	1	1	2

Because respondents checked multiple times percentages and bottom totals are eliminated. Taken from PCHS and YCHS survey responses.

In summary, the interviews of the New Hampshire and Maine statewide professions seemed to reveal some awareness of elderly abuse and neglect but the problem was not uniformly defined, acknowledged, or referred. Generally, there did not seem to be a diagnostic or coding category for this problem, and thus there was little statistical information yielding incidence and prevalence other than the recollections of personnel. Citings of elderly abuse by physicians, visiting nurse associations, homemaker home health aide associations, and welfare seemed to indicate that this is a health problem in New Hampshire and Maine.

A questionnaire was administered to nurses, home health aides, and homemakers at PCHS and YCHS because it was felt that elderly abuse and neglect could best be described by questioning those who were likely to view it in its natural environment, the home. More than half of all the questionnaires returned cited elderly abuse which means in these two agencies the problem is recognized and it is prevalent.

Analysis of the questionnaire results from these two agencies revealed that the elderly abuse victim (host) is usually female, 75+, and has a physical or mental disability which prevents the victim from meeting daily needs. The abuser (agent) is usually a family member and lives with the victim in the home (environment). Personnel at PCHS and YCHS cited stress as usually coinciding with abuse. The victims seemed to be stressed by medical problems, long-term financial problems, and a limited education. The abuser experienced stress over loss of independence, an alcohol or drug problem, long-term financial problems, and a limited education. The family was experiencing stress from long-term medical problems.

The occurrence of abuse did not strongly seem to be associated with any special time although YCHS had more citings of fall and 6 p.m. to 12 midnight.

Respondents intervention was most likely to be increasing in home services, and discussing the problem with physician and abuser. Outside placement of the victim was only considered in an emergency. Placement seems to be difficult presently because it is costly and there is a lack of nursing home beds. A variety of referral sources were utilized in the intervention process.

The barrier that was most encountered during intervention was lack of cooperation by abuser and family. Despite barriers, 79 percent of the time the problem seemed to be resolved although sometimes the victim died (cause of death was not determined).

Chapter V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

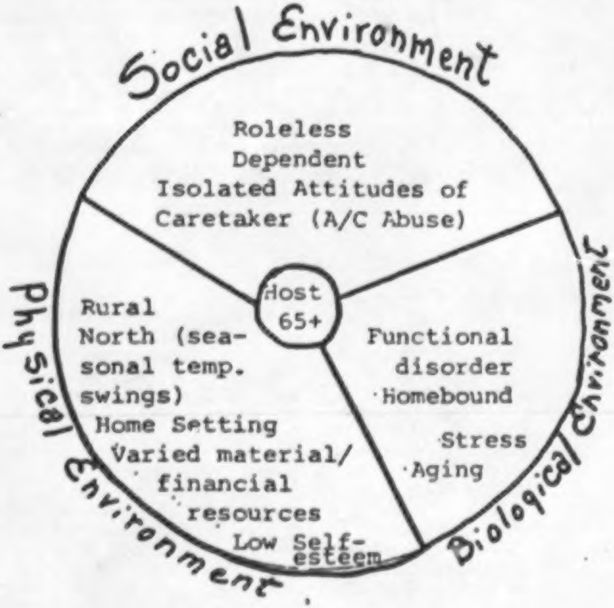
In order to determine whether abuse and neglect was perceived as a health problem in southern Maine and New Hampshire, a two-phased descriptive study using convenience sampling was conducted. The literature review revealed a vast amount of current interest in the problem of elderly abuse of five types; physical, financial/material, psychological, self-inflicted, and violation of rights. Results of a telephone interview survey of 31 Maine and New Hampshire health, social service, legal, and civil agencies revealed a developing consciousness of the problem. The sense among all contacted was that the problem of elderly abuse and neglect has not had sufficient definition or attention, and that cooperation among health workers, social service, advocacy, and law enforcement agencies with official arms of the executive branch of government was possible and desirable.

In the second phase of the study, 29 cases, probably not unduplicated, were remembered from the caseloads of 51 community health nurses and aides. These represent an estimated period prevalence rate of 4.5 percent of clients over 65 years old known to have sustained some degree of abuse or neglect over the past 18 months. Comments added on the questionnaire, and by those interviewed, indicated the existance of all five catagories of abuse. The use of a specific definition during the questionnaire phase generated more memories than did a general inquiry during the first phase. Thus, our first hypothesis that elderly abuse and neglect is a heretofore unrecognized problem in southern Maine and New Hampshire was only partially proved; recognition and concern has begun, but further diagnosis and documentation is needed to establish its magnitude and severity.

We were able to conclude that insufficient data is currently available to establish incidence or prevalence with certainty, but that some degree of elderly abuse/neglect is known to exist in Portsmouth, N.H., and Biddeford-Saco, Maine. Based on the study data and the literature reviewed, we believe that the problem can be generalized to some extent to the entire population, at least in the United States, since the bulk of elderly citizens reside at home with or near family members. Both health and socioeconomic factors were seen as related, but further study is necessary and recommended to determine etiology. Some data and the literature suggest that retrospective studies into patterns of family violence and relationships would be worthwhile.

The dynamics of time, person, and place do not emerge as clearly. The host in which we were interested is more than 65 years old and more often over 75, functionally disabled, roleless, dependent for at least some basic survival need, lonely, and fearful. She resides in a home setting of varying resources with or near one or more of her adult children, who may themselves be over 60 years old. The time of abusive or neglectful actions remains unclear but appears cyclical, precipitated by intolerable stress, often expressed in substance abuse as well as violence/neglect of others. Indeed investigation of the variable of time, suggested by D. Johnson to be cyclical (See figure 3), may not be as important as further person and place psychosocial study. Rather, the quality of relationships and the coping mechanisms which fail appear to be more productive areas for further study, particularly as they may suggest specific interventions to prevent intolerable stress in day-to-day family interaction and to redirect or diffuse the energies which are released in violent or neglectful behaviors. Figure 8 describes some of the biologic, physical and socioenvironmental factors in elderly abuse/neglect revealed by this study.

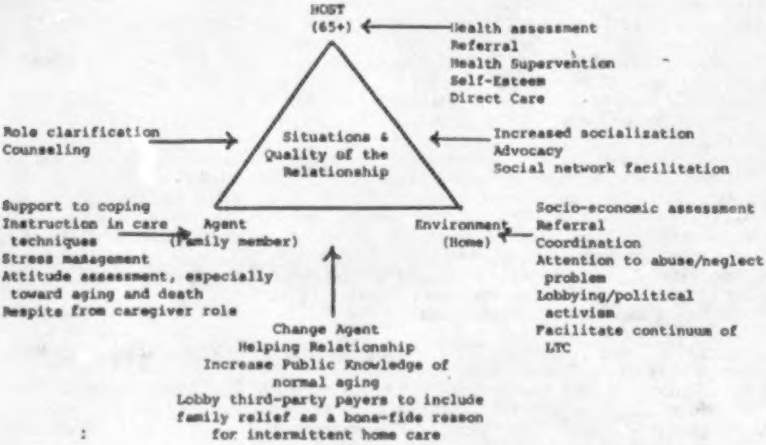
FIGURE 8.—Wheel model depicting the elderly and neglect


Social Environment
Roleless
Dependent
Isolated Attitudes of
Caretaker (A/C Abuse)
Host
65+
Physical Environment
Rural
North (seasonal temp. swings)
Home Setting
Varied material/
financial
resources
Low Self-esteem
Biological Environment
Functional
disorder
·Homebound
·Stress
·Aging

Our second hypothesis, that community health agencies can contribute to the detection and prevention of elderly abuse and neglect in the populations they serve, was supported. A network of community resources exist in both Portsmouth, N.H. and Biddeford-Saco, Maine, who are interested in and equipped to form a matrix of supportive services. Based on data to date, it would appear that little additional or new funding in terms of total health care expense would be needed to intervene in this problem. Rather, attention to lack of intra-agency coordination which was evident in the agencies surveyed is needed; probably a single, funded coordinator in each catchment area. Such coordination is an effective and appropriate role for community helath agencies, partiuclarly in the current climate of renewed interest community-based long-term care as an alternative to institutionalization. The emphasis on and skills in family-oriented assessment and planning, casefinding, referral, and coordination of the community health nurse make her pivotal in detection of the problem and prevention of further physical or psychological damage through nursing interventions designed to interrupt the cycle.

Figure 9 suggests the kinds and thrusts of such nursing interventions to individuals, families, and groups:

FIGURE 9.—Points for community health nursing intervention in the epidemiological model of elderly abuse/neglect


HOST
(65+)
Health assessment
Referral
Health Supervention
Self-Esteem
Direct Care
Role clarification
Counseling
Situations & Quality of the Relationship
Increased socialization
Advocacy
Social network facilitation
Support to coping
Instruction in care techniques
Stress management
Attitude assessment, especially toward aging and death
Respite from caregiver role
Agent
(Family member)
Environment
(Home)
Socio-economic assessment
Referral
Coordination
Attention to abuse/neglect problem
Lobbying/political activism
Facilitate continuum of LTC
Change Agent
Helping Relationship
Increase Public Knowledge of normal aging
Lobby third-party payers to include family relief as a bona-fide reason for intermittent home care

Some evidence that the communities studied do condone, contribute to, or perpetuate elderly abuse and neglect via a lack of recognition is suggested by survey comments made. The high proportion of abuse citings involving victims over 75 indicates a need to keep and analyse the population segment more vigorously. Appropriate leadership in problem definition, publicity, data gathering research, and focusing community opinion toward improved legislation, mandatory reporting, and governmental protocol is also a bona fide community health nursing advocacy role. Since the bulk of programs for the elderly are focused on the few who are institutionalised or acutely ill (Shanas, page 14), changes in public attitude will be a prerequisite for attacking the problem for the many.

Time and resource constraints seriously weakened this study. The use of a relatively small convenience questionnaire survey which did not yield an unduplicated count nor sufficiently isolate place (environmental) and financial data makes prediction impossible. During the first phase, there was no consistency among interviewers in the questions asked of other agencies. Little useful family or health history data was gathered, nor pertinent attitudinal information.

Nonetheless, the study's purpose was to develop an overview of the problem of elderly/abuse and neglect in outhern New Hampshire and Maine, and that purpose was accomplished. The intuitive, experiential sense that support an education group programs focusing on the needs of elderly at home was borne out. Concern for the quality of life for families at home has been organised into an intervention fromework. Perhaps the most significant finding, in this age of labels under the professional guise of taxonomy, is that only by defining the problem is it possible to determine the resultant morbidity and mortality, the first step toward detection and ultimately prevention.

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Appendix 2

MODEL ADULT PROTECTIVE SERVICES ACT

INTRODUCTORY COMMENTS

As with any model statute, the general purpose of the Model Protective Services Act is to provide prototype legislation which the States may utilize in drafting their own protective services statutes. This act also has three particular objectives: (1) To provide the authority for a State to develop, organize, and supervise a State program of protective services; (2) to outline guidelines and criteria for the design and operation of a protective services system; (3) to authorize the courts to issue orders for involuntary protective services and protective placement after making specific findings and following designated procedures.

The last objective should be seen in a wider context. All States currently permit certain types of involuntary intervention in the lives of their citizens, including the elderly. The kinds of intervention relevant to the elderly are typically authorized through civil commitment proceedings involving admission to a State mental hospital or guardianship proceedings transferring authority over the ward or his property to a court-appointed fiduciary. This act does not modify or replace such legislation, but rather is intended to provide legal authority to intervene involuntarily in situations requiring less drastic interference with a person's civil rights.

Two specific situations receive particular attention. The first concerns the person whose health or living conditions pose serious danger to himself or others and consequently short-term emergency action is necessary. The court order for this problem is called an "emergency order for protective services." Intervention for a longer period must follow the existing guardianship laws.

The other situation for which legally authorized intervention is necessary is the involuntary transfer of an elderly person's residence to an institution other than a mental hospital, such as a nursing home. This intervention is referred to as "protective placement."

In both instances, current State law concerning civil commitment or guardianship is either wide of the mark, which is to fill a particular need of a person, or offers too drastic a solution by declaring the person incompetent and stripping him of all or most of his rights. The Model Protective Services Act attempts to fill the gaps in existing law and at the same time to authorize only the least restrictive and appropriate form of intervention.

This explanation of the act's methods for authorizing involuntary intervention through legal channels should not, however, divert attention from the act's other objectives. The protective services system contemplated by this act will function on a voluntary basis in the vast majority of cases. Indeed, a system which requires frequent involuntary intervention may well be suspect. It is expected that the wide range of services provided in this system to assist the elderly in maintaining independent lifestyles will prove attractive to them and invite their cooperation. The potential for involuntary intervention and, hopefully, its infrequent but necessary occurrence under the provisions of this act, will distinguish the protective services system created by this act from existing programs of home or community-centered services.

Accompanying the Model Protective Services Act is other suggested legislation. One important adjunct is the Model Public Guardian Act designed to provide guardianship services for the financially needy. Suggested revisions of the State guardianship, conservatorship, and power of atttorneys laws based largely on the Uniform Probate Code are also proposed. The final proposal contains a short but significant change in State civil commitment to require courts to consider whether less drastic alternative programs than commitment are available and adequate.

The net results of the enactment of all this proposed legislation will be a program of services to the elderly to assist them to avoid institutionalization and a spectrum of alternative forms of legally authorized intervention in the elderly person's life calibrated to provide only the specific services necessary to meet immediate needs and avoid more drastic interference.

SUGGESTED LEGISLATION

(Title, enacting clause, etc.)

SECTION. 1. (Short title.) This act may be cited as the Adult Protective Services Act.

SECTION 2. (Declaration of Policy and Legislative Intent.) The legislature of the State of [————] recognizes that many elderly citizens of the State, because of the infirmities of aging, are unable to manage their own affairs or to protect themselves from exploitation, abuse, neglect, or physical danger. Often such persons cannot find others able or willing to render assistance. The legislature intends through this act to establish a system of protective services designed to fill this need and to assure their availability to all elderly citizens. It is also the intent of the legislature to authorize only the least possible restriction on the exercise of personal and civil rights consistent with the person's need for services, and to require that due process be followed in imposing such restrictions.

Comments on section 2

The protective services system established by this act is designed to benefit only the elderly because, as an identifiable segment of society, their need for such services is imperative. Moreover, many States have already developed for their elderly citizens systems of supportive and preventive services which can be readily integrated into the proposed protective services system. The additional costs of the proposed program for the elderly will therefore be small, as compared with the costs of creating an entirely new services program for all residents of the State.

SECTION 3. Definitions—As used in this act:

(1) "Conservator" means a person who is appointed by a court to manage the estate of a protected person.

(2) "Court" means the court or branch having jurisdiction in matters relating to the affairs of decedents, this court in this State is known as [ ].

(3) "Department" means the [State agency responsible for community-based services to the elderly].

(4) "Elderly" means a person 60 years of age or older, who is a resident of the State.

(5) "Emergency" means that an elderly person is living in conditions which present a substantial risk of death or immediate and serious physical harm to himself or others.

(6) "Emergency services" are protective services furnished to an elderly person in an emergency pursuant to the provisions of section 10 of this act.

(7) "Geriatric evaluation service" is a team of medical, psychological, psychiatric, and social work professionals established by the [State agency responsible for community-based services to the elderly] for the purpose of conducting a comprehensive physical, mental, and social evaluation of an elderly person for whom a petition has been filed in a court for commitment to a mental hospital, appointment of a conservator or guardian, an emergency order for protective services, or an order for protective placement.

(8) "Guardian" means a person who has qualified as a guardian of an incapacitated person pursuant to testamentary or court appointment, but excludes one who is merely a guardian ad litem.

(9) "Hazardous living conditions" means a mode of life which contains a substantial risk of or actual exploitation, abuse, neglect, or physical danger.

(10) "Incapacitated person" means [alternative A: any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other causes (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person]. [Alternative B: any person for whom a guardian has been appointed by the court.]

(11) "Independent living arrangements" means a mode of life maintained on a continuing basis outside of a hospital, Veterans' Administration hospital, nursing home, or other facility licensed by or under the jurisdiction of any State agency.

(12) "Infirm person" means a person who, because of physical or mental disability, is substantially impaired in his ability to provide adequately for his own care or custody.

(13) "Interested person" means any adult relative or friend of an elderly person, or any official or representative of a protective services agency or of any public or nonprofit agency, corporation, board or organization eligible for designation as a protective services agency.

(14) A "protected person" is a person for whom a conservator has been appointed or other protective order has been made.

(15) "Protective placement" means the transfer of an elderly person from independent living arrangements to a hospital, nursing home, or domiciliary or residential care facility, or from one such institution to another, for a period anticipated to last longer than 6 days.

(16) "Protective services" means the services furnished by a protective service agency or its delegate, as described in section 6 of this act.

(17) "Protective services agency" means a public or nonprofit private agency, corporation, board or organization authorized by the Department pursuant to section 4(f) of this act to furnish protective services to elderly infirm, protected or incapacitated persons and/or to serve as conservators or guardians of the person for elderly protected or incapacitated persons upon appointment by a court.

(18) "Public guardian" means the office of the public guardian.

(19) A "ward" is a person for whom a guardian has been appointed.

Comments on section 3

The terminology of the Uniform Probate Code has been adopted here to describe the persons principally involved in guardianship and conservatorship proceedings. "Incapacitated persons" are those for whom guardians (of the person) are appointed, while "protected persons" are those for whom conservators have been appointed or other protective orders issued by a court.

The term "infirm persons" refers to the elderly whose degree of impairment is substantial, but is not so serious as to justify appointment of a guardian or conservator.

SECTION 4. Establishment of protective services system.

(*a*) Planning and development of system.—The Department shall develop a coordinated system of protective services for elderly infirm and incapacitated persons. In planning this system, the Department shall obtain the advice of agencies, corporations, boards, and associations currently involved in the provision of social, health, legal, nutritional and other services to the elderly, as well as of organizations of the elderly themselves.

(*b*) Advisory board.—In order to provide continuing advice to the Department concerning the protective services system, an advisory board composed of [nine] members appointed by the Governor is established.

(*c*) Provision of services by Department.—The Department may provide direct protective services.

(*d*) Contracts for services.—The Department may contract with any protective service agency for the provision of protective services.

(*e*) Utilization of resources.—The Department shall utilize to the extent appropriate and available existing resources and services of public and nonprofit private agencies in providing protective services.

(*f*) Designation of protective services agencies.—The Department may designate any public or nonprofit private agency, corporation, board or organization as a protective services agency. The Department shall issue regulations establishing criteria and procedures for the designation of protective services agencies. Preference shall be given to agencies with consumer or other citizen representation.

(*g*) Limitation.—No public or private agency, corporation, board or organization may furnish protective services to an elderly person under court order or serve as guardian of the person unless the Department has designated such a body as a protective services agency pursuant to subsection (*f*) above.

(*h*) Emergencies.—The Department shall designate at least one protective services agency in each [city and county] which shall be responsible for rendering protective services in an emergency.

(*i*) Coordination and supervision of system.—Upon establishment of the protective services system, the Department shall be responsible for continuing coordination and supervision of the system. In carrying out these duties, the Department shall:

(1) Adopt rules and regulation for the system;

(2) Continuously monitor the effectiveness of the system and perform evaluative research about it; and

(3) Utilize to the extent available grants from Federal, State, and other public and private sources to support the system.

Comments on section 4

This section sets forth the powers and duties of the State agency responsible for organizing a protective services system. The structure and detailed organization of this system, however, are left to the agency and are not included in the legislation.

The chief duties of the agency are: (1) to develop a protective services system; (2) to obtain wide ranging professional and consumer advice in planning and operating the system; (3) as part of the system, to designate local protective services agencies for emergency situations; and (4) to coordinate and supervise the system on an ongoing basis.

The State agency is given a variety of powers in providing protective services, but States may wish to select those it believes most in accord with its system and resources and therefore delete other powers. Thus the agency itself may provide protective services; it may contract for these services at State expense; it may simply designate existing organizations as providers of protective services; or it may choose a combination of these approaches. Subsection (*e*) states a preference for the use of existing community resources, while subsection (*h*) indicates a further preference for organizations with broad citizen representation.

Where protective services are to be furnished by an organization, subsection (*g*) requires this organization to be approved for this purpose by the State agency. The requirement for approval as well as its power will enable the State agency to limit the provision of services to responsible organizations which meet agency criteria.

SECTION 5. Protective services agencies.

(*a*) Powers.—A protective services agency is authorized:

(1) to furnish protective services to an elderly person with his consent;

(2) to petition the court for appointment of a conservator or guardian, for issuance of an emergency order for protective services, or for an order for protective placement;

(3) to furnish protective services to an elderly infirm person without his consent on an emergency basis pursuant to section 10 of this act;

(4) to furnish protective services to an elderly incapacitated or protected person with the consent of such person's guardian or conservator;

(5) to serve as conservator, guardian, or temporary guardian of an elderly protected or incapacitated person;

(6) to enter into protective arrangements and to conduct single transactions authorized by a court pursuant to [section 5-409 of the Uniform Probate Code].

(*b*) Reports.—A protective services agency shall make such reports as the Department or a court may require.

Comments on section 5

Once having been designated a "protective services agency" by the State agency, the protective services agency is required to obtain permission before it may provide services. This permission may come from the elderly person himself (subsection (*a*)(1)), that person's conservator or guardian (subsection (*a*)(4)), or a court. Court authorization will be given by issuance of an emergency order (subsection (*a*)(3)), by appointment of the protective services agency as conservator or guardian (subsection (*a*)(5)), or by granting power to conduct particular transactions for the elderly person (subsection (*a*)(6)).

The protective services agency is also empowered under subsection (*a*)(2) to petition the court for appointment of a conservator or guardian and for issuance of orders for protective services on an emergency basis or for protective placement.

SECTION 6. Nature of Protective Services.

(*a*) Definition.—Protective services are services furnished by a protective services agency or its delegate to an elderly infirm, incapacitated, or protected person with the person's consent or appropriate legal authority, in order to assist the person in performing the activities of daily living, and thereby maintain independent living arrangements and avoid hazardous living conditions.

(*b*) Services.—The services furnished in a protective services system may include but are not limited to: social case work; psychiatric and health evaluation; home care; day care; legal assistance; social services; health care; and other services consistent with the purpose of this act. Such services do not include protective placement.

(*c*) Service-related activities.—In order to provide the services listed in subsection (*a*) above, a protective services system may include but is not limited to the following service-related activities: outreach; identifying persons in need of services; counselling; referring persons for services; evaluating individuals; arranging for services; tracking and following up cases; referring persons to the public guardian; petitioning the courts for the appointment of a conservator or guardian of the person; and other activities consistent with the purposes of this act.

(*d*) Costs of services.—The costs of providing protective services shall be borne by the provider of such services, unless the elderly person agrees to pay for them or a court authorizes the provider to receive reasonable reimbursement from the person's assets after a finding that the person is financially able to make such payment.

Comments on section 6

The definition of protective services in subsection (*a*) indicates that such services are intended to be only a specific portion of a broader program whose purpose is to prevent or delay institutionalization of the elderly. The characteristics that distinguish protective services from these larger programs are: (1) their target population is the infirm, incapacitated, or protected elderly: (2) the services are provided by a designated protective services agency or its delegate; and (3) unless the elderly client consents to accept the services, the protective service agency may intervene only with court authorization.

Subsections (*b*) and (*c*) provide examples of the services that may be included in a protective services program. Protective placement, defined in section 3(15) above, is excluded from these services. Section 11 establishes special proceedings to obtain court authorization for involuntary transfers of residence.

Subsection (d) establishes the presumption that the protective services will be paid for by the provider agency, which may in turn be reimbursed from Federal or State sources if such funding is available. The provider agency may obtain reimbursement from the elderly person only if the client consents or a court authorizes such payment. The criterion to be applied by the court is deliberately framed in general terms, viz, the "financial ability" of the elderly person to afford the services. See also section 9(*c*). "Financial ability" is a variable dependent on the nature, extent, and liquidity of the person's assets; his disposable net income; the type, duration and complexity of the services required and rendered; and any other foreseeable expenses.

A rigid means test should be avoided. On the other hand, elderly persons who desire to receive protective services and can afford to pay for them are not precluded from receiving them under this section.

In the event that the elderly client will pay for protective services, the criterion for reimbursement is the reasonable cost of the services. See also section 9(*c*).

SECTION 7. Geriatric evaluation service—

(*a*) Establishment.—The Department shall establish a geriatric evaluation service for the purpose of conducting a comprehensive physical, mental, and social evaluation of an elderly person for whom a petition has been filed in a court for commitment to a mental hospital, appointment of a conservator or guardian, an emergency order for protective services, or an order for protective placement.

(*b*) Evaluation.—The evaluation of an elderly person conducted by the geriatric evaluation service should include at least the following:

(1) The name and address of the place where the person is residing and of the person or agency, if any, who is providing services at present;

(2) A description of the treatment and services, if any, presently being provided to the person;

(3) An evaluation of the person's present physical, mental, and social conditions; and

(4) A recommendation concerning the least restrictive course of services, care or treatment consistent with the person's needs.

(*c*) Costs.—The cost of this evaluation should be borne by the Department.

Comments on section 7

The geriatric evaluation service (GES) is a team of medical, psychological, psychiatric, and social work professionals. Its function is to provide the courts with impartial professional advice to assist them in making determinations which by their very nature involve the assessment of an elderly person's capacity to continue independent living and decisionmaking. The direct responsibility of the GES is to the court, not the petitioner or the elderly person, and therefore its recommendations will hopefully be free of partisanship. For the same reason, the costs of this evaluation are borne by the State under subsection (*c*) instead of by the parties to the proceedings. At the same time, however, the evaluation conducted by the GES is not exclusive, and therefore the parties to the proceedings may also offer similar evaluations in evidence. See section 12(*a*) (4).

One important feature of the evaluation described in subsection (*b*) (4) is the GES' recommendation concerning the least restrictive course of services, care or treatment consistent with the elderly person's needs. The theme that intervention should be as minimal as necessary to achieve valid goals for the person appears elsewhere in the act. See sections 9(*b*), 11(*a*) (6), 11(*g*) (3), and 11(*l*). Section 14 also authorizes the elderly person to appeal the court's finding on this issue required in section 11(*a*) (6).

SECTION 8. Voluntary protective services.

(*a*) Consent required.—Any elderly person may receive protective services, provided the person requests or affirmatively consents to receive these services. If the person withdraws or refuses consent, the services shall not be provided.

(*b*) Interference with services.—No person shall interfere with the provision of protective services to an elderly person who requests or consents to receive such services. In the event that interference occurs on a continuing basis, the Department, a protective services agency, or the public guardian may petition the court to enjoin such interference.

(*c*) Publicity for services.—The Department shall publicize throughout the State the availability of protective services on a voluntary basis for elderly persons.

Comments on section 8

It is expected that protective services will ordinarily be provided to the elderly who desire such assistance. In such case, proceedings to establish guardianships or conservatorships, if necessary, will be nonadversarial.

Subsections (*b*) and (*c*) are consistent with the principle of voluntary acceptance of services by prohibiting interference with these services by others and by requiring the State agency to make the elderly aware of the availability of this assistance.

SECTION 9. Involuntary Protective Services.

(*a*) Lack of consent.—If an elderly person lacks the capacity to consent to receive protective services, these services may be ordered by a court on an involuntary basis, (1) through an emergency order pursuant to section 10 of this act, or (2) through appointment of a conservator or guardian pursuant to [the provisions of the Model Guardianship and Conservatorship Act].

(*b*) Least restrictive alternative.—In ordering involuntary protective services, the court shall authorize only that intervention which it finds to be least restrictive of the elderly person's liberty and rights, while consistent with his welfare and safety. The basis for such finding shall be stated in the record by the court.

(*c*) Payment for services.—The elderly infirm, incapacitated, or protected person shall not be required to pay for involuntary protective services unless such payment is authorized by the court upon a showing that the person is financially able to pay. In this event the court shall provide for reimbursement of the reasonable costs of the services.

Comments on section 9

Protective services may be provided to elderly persons without their consent only with court authorization. Such authorization may take two forms: (1) the issuance of an emergency order under section 10 or (2) the appointment of a conservator or guardian. If this authorization has not been obtained or has been denied and the elderly person refuses to accept the services voluntarily, no organization or individual may intervene on its own authority.

The underlying principle here is that the elderly person alone should decide whether or not to accept these services, regardless of the opinion of others about the possible detrimental effects on the person who refuses to accept assistance. Involuntary intervention authorized by the courts, therefore, requires findings that: (1) The elderly person lacks capacity to consent to services, for example, to make intelligent decisions about his person or property; and (2) that conditions exist justifying an emergency order under section 10 or appointment of a conservator or guardian. It is not enough that the older person refuses services or other persons disagree with his decisions.

Discussions of subsection (*b*) appear in the comments on section 7 and of subsection (*c*) in the comments on section 6.

SECTION 10. Emergency order for protective services.

(*a*) Petition and findings.—Upon petition by the Department, the public guardian, a protective services agency, or an interested person, a court may issue an order authorizing the provision of protective services on an emergency basis to an elderly person after finding on the record, based on clear and convincing evidence, that:

(1) the elderly person is infirm or incapacitated, as defined in section 3 of this act;

(2) an emergency exists, as defined in section 3(5) of this act;

(3) the elderly person lacks the capacity to consent to receive protective services;

(4) no person authorized by law or court order to give consent for the elderly person is available to consent to emergency services; and

(5) the proposed order is substantially supported by the findings of the geriatric evaluation service, or if not so supported, there are compelling reasons for ordering services.

(*b*) Limitations on emergency order. In issuing an emergency order, the court shall adhere to the following limitations:

(1) Only such protective services as are necessary to remove the conditions creating the emergency shall be ordered; and the court shall specifically designate the approved services in its order.

(2) Protective services authorized by an emergency order shall not include hospitalization or a change of residence unless the court specifically finds such action is necessary and gives specific approval for such action in its order.

(3) Protective services may be provided through an emergency order only for 72 hours. The original order may be renewed once for a 72 hour period upon a showing to the court that continuation of the original order is necessary to remove the emergency.

(4) In its order the court shall appoint the petitioner, another interested person, or the public guardian as temporary guardian of the elderly person with responsibility for the person's welfare and authority to give consent for the person for the approved protective services until the expiration of the order.

(5) The issuance of an emergency order and the appointment of a temporary guardian shall not deprive the elderly person of any rights except to the extent validly provided for in the order or appointment.

(6) To implement an emergency order, the court may authorize forcible entry of the premises of the elderly person for the purpose of rendering protective services or transporting the person to another location for the provision of such services only after a showing to the court that attempts to gain voluntary access to the premises have failed and forcible entry is necessary. Persons making authorized forcible entry shall be accompanied by a peace officer.

(*c*) Contents of petition.—The petition for an emergency order shall set forth the name, address, and interest of the petitioner; the name, age and address of the elderly person in need of protective services; the nature of the emergency; the nature of the person's disability, if determinable; the proposed protective services; the petitioner's reasonable belief, together with facts supportive thereof, as to the existence of the facts stated in subsection (*a*)(1) through (4) above; and facts showing petitioner's attempts to obtain the elderly person's consent to the services and the outcomes of such attempts.

(*d*) Notice of petition.—Notice of the filing of such petition, and other relevant information, including the factual basis of the belief that emergency services are needed and a description of the exact services to be rendered, the rights of the person in the court proceeding, and the consequences of a court order, shall be given to the person, to his spouse, or if none, to his adult children or next of kin, to his guardian, if any, to the public guardian, and to the geriatric evaluation service. Such notice shall be given in language reasonably understandable by its intended recipients at least 24 hours prior to the hearing for emergency intervention. The court may waive the 24-hour notice requirement upon showing that (1) immediate and reasonably foreseeable physical harm to the person or others will result from the 24-hour delay, and (2) reasonable attempts have been made to notify the elderly person, his spouse, or if none, his adult children or next of kin, his guardian, if any, and the public guardian. Notice of the court's final order shall also be given to the above named parties.

(*e*) Hearing on petition.—Upon receipt of a petition for an emergency order for protective services, the court shall hold a hearing pursuant to the provisions of section 12 of this act. This hearing shall be held no earlier than 24 hours after the notice required in subsection (*d*) above has been given, unless such notice has been waived by the court.

(*f*) Review of court order.—The elderly person, the temporary guardian or any interested person may petition the court to have the emergency order set aside or modified at any time, notwithstanding any prior findings by the court that the elderly person is infirm.

(*g*) Report.—Where protective services are rendered on the basis of an emergency order, the temporary guardian shall submit a report describing the circumstances including the name, place, date, and nature of the services, and the use of forcible entry, if any, to the court and the public guardian. This report shall become part of the court record.

(*h*) Continued need for services.—If the person continues to need protective services after the renewal order provided in subsection (*b*)(3) above has expired, the temporary guardian or the public guardian shall immediately petition the court to appoint a conservator or guardian and/or to order protective placement pursuant to section 11 of this act.

(*i*) Immunity of petitioner.—The petitioner shall not be liable for filing the petition if he acted in good faith.

(*j*) Emergency placement.—When from personal observation of a peace officer, it appears probable that an elderly person will suffer immediate and irreparable physical injury or death if not immediately placed in a health care facility, that the elderly person is incapable of giving consent, and that it is not possible to follow the procedures of this section, the peace officer making such observation may transport the elderly person to an appropriate medical facility. The Department and the persons entitled to notice under subsection (*d*) above shall be notified of such detention within 4 hours. The Department shall file a petition pursuant to subsection (*a*) above within 24 hours after the transfer of the elderly person has taken place. The court shall hold a hearing on this petition and render its decision within 48 hours after the transfer has occurred.

Comments on section 10

This section provides the legal authority to deal with a situation where an elderly person is living in highly dangerous conditions or is himself in a state of severe physical deterioration, and therefore swift action is necessary to provide a remedy. Despite the emergency character of the situation, court authorization on an expedited basis is still required for involuntary intervention. The only exception to the need for a court order is the provision for emergency placement in subsection (*j*).

Subsection (*a*) lists the findings which the court must make to support issuance of an order for protective services to be furnished in an emergency. These findings must be supported by "clear and convincing evidence" and not merely a preponderance of the evidence to emphasize the caution with which involuntary intervention must be authorized. The basis for these findings should appear in the court record and are appealable under section 14.

Even though a court finds issuance of an order to be justified, the scope and duration of the order are subject to the limitations of subsection (*b*). In conformity with the "least restrictive action" principle enunciated earlier, the court may authorize only those services needed to remove the emergency, not an extended care program of rehabilitation or treatment designed to restore the elderly person to his full potential. These services must be specified in the court order, and may not include hospitalization or a change of residence except as provided in subsection (*b*) (2). Two 72-hour programs of services are permissible under subsection (*b*) (3). If emergency protective services are needed beyond this 6-day period, proceedings for appointment of a guardian or conservator or full protective placement must be initiated, as provided in subsection (*h*). Forcible entry of the elderly person's premises to implement the court order is also controlled in subsection (*b*) (16).

To avoid having the elderly person exclusively in the care of the provider of services for the duration of the court order, subsection (*b*) (4) requires the court to appoint a temporary guardian for this period whose duties are to be responsible for the elderly person's welfare, and to petition for further court actions under subsection (*h*) if services continue to be necessary. The provider of services may be appointed as temporary guardian if the court so chooses, but it is preferable that some other party serve as guardian to prevent the elderly person from becoming completely dependent on the provider even for the limited duration of the emergency order.

This section is intended to replace for elderly persons section 5–310 of the Uniform Probate Code, which authorizes the appointment of a temporary guardian in two situations. The UPC provides that, when an incapacitated person has no guardian and an emergency exists, the court may exercise the power of a guardian pending notice and hearing. This provision appears to be unnecessary in the light of section 10 of the Adult Protective Services Act. Under the UPC a temporary guardian may also be appointed, with or without notice, when an appointed guardian is not effectively performing his duties and the court finds that the welfare of the incapacitated person requires immediate action. Again, the combination of a short-term guardianship under section 10 of this act and further proceedings for a new appointment of a permanent guardian seems better suited to protect the interests of the elderly person because of their strict criteria and procedural requirements.

Subsections (*c*), (*d*), and (*e*) describe the procedure to be followed by the petitioner and the court for issuance of an emergency order for protective services. A philosophy of full disclosure has been adopted, both as to the contents of the petition and as to the persons entitled to be notified of the filing of the petition. Such disclosure will afford interested parties the opportunity to intervene or participate in the proceedings, to assist the court, and to protect the interests of the elderly person.

The provision for emergency placement in subsection (*j*) attempts to deal with the situation where there is not sufficient time to obtain an emergency court order. Peace officers are authorized to make on-the-spot determinations based on personal observation that certain specified conditions probably exist. This determination is analogous to decisions based on probable cause, with which police are familiar in the areas of warrantless arrests and searches in criminal contexts. Once the transfer to a health care facility has occurred, however, appropriate parties must be notified of this action and regular proceedings under section 10 must be started. The court is required to reach a decision within a specified time limit because transfer of the elderly person has already occurred and should be validated or not as quickly as possible.

SECTION 11. Protective placement.

(*a*) Findings.—If the elderly person refuses to consent, protective placement shall not take place unless ordered by a court after a finding on the record based on clear and convincing evidence that:

(1) The elderly person is incapacitated, as defined in section 3(10) of this act [or as defined in sections ——— or ——— of the State code], and a petition to appoint a guardian accompanies this petition for protective placement;

(2) The elderly person is so totally incapable of providing for his own care or custody that his condition creates a substantial risk of serious physical harm to himself or others. Serious harm may be occasioned by overt acts or acts of omission;

(3) The elderly person has a disability which is permanent or likely to be permanent;

(4) The elderly person needs full-time residential care or treatment;

(5) The proposed order is substantially supported by the recommendation of the geriatric evaluation service, as provided for in subsection (*g*) below, or if not so supported, there are compelling reasons for ordering such placement; and

(6) No less restrictive alternative course of care or treatment is available which is consistent with the incapacitated person's welfare and safety.

(*b*) Who may petition.—The Department, a protective services agency, a conservator, a guardian, the public guardian, or a person applying for a conservatorship or guardianship pursuant to [the provisions of the uniform probate code] may petition the court for protective placement.

(*c*) Contents of petition.—The petition shall state with particularity the factual basis for the allegations specified in subsection (*a*) above and shall be based on the petitioner's personal knowledge of the elderly person alleged to need protective placement.

(*d*) Order of consideration.—A petition for appointment of a conservator or guardian accompanying a petition for protective placement shall be heard and decided prior to the petition for protective placement.

(*e*) Notice of petition.—Notice of a petition for protective placement shall be served upon the elderly person sought to be placed by personal service at least 10 days prior to the time set for a hearing. Notice shall be given in language reasonably understandable by the elderly person, and he shall be informed orally of its complete contents. The notice shall include the names of all petitioners, the factual basis of the belief that protective placement is needed, the rights of the elderly person in the court proceedings, the name and address of the proposed placement, and the consequences of an order for protective placement. The person serving the notice shall certify to the court that the petition has been delivered and notice given. Notice shall also be given to the person's guardian ad litem; legal counsel; persons having physical custody of the elderly person whose names and addresses are known to the petitioner or can with reasonable diligence be ascertained; any governmental or private body or group from whom the elderly person is known to be receiving aid; the geriatric evaluation service; the public guardian; and such other persons or entities as the court may require.

(*f*) Hearing on petition.—Upon receipt of a petition for protective placement, the court shall hold a hearing pursuant to the provisions of section 12 of this act.

(*g*) Evaluation of person.—In order to make the finding required in subsections (*a*) (2), (3), (4), and (6) above, the court shall direct that a comprehensive evaluation of the elderly person alleged to be in need of placement be conducted by the geriatric evaluation service. The evaluation shall include at least the following information:

(1) The address of the place where the person is residing and the person or agency, if any, which is providing care treatment or services at present;

(2) A résumé of the professional treatment and services provided to the person by the Department or agency, if any, in connection with the problem creating the need for placement;

(3) A medical, psychological, a psychiatric, and social evaluation and review, where necessary, and any recommendations for or against maintenance or partial legal rights as provided in ———— of this code. Such evaluation and review shall include recommendations for placement consistent with the least restrictive environment required.

(*h*) Choice of facilities.—In ordering protective placement, the court shall give consideration to the choice of residence of the elderly person. The court may order placement in such facilities as hospitals, nursing homes, domiciliary or personal care facilities, sheltered care residences, foster care homes, or other appropriate facilities. It may not order placement in facilities for the acutely mentally ill; placement in such facilities is governed by [the civil commitment provisions] of this code.

(*i*) Duration of order.—The court may authorize protective placement of an elderly person for a period not to exceed 6 months.

(*j*) Renewal of order.—At the time of the expiration of an order for protective placement, the guardian, the original petitioner, or any interested person may petition the court to extend its order for protective placement for an additional period not to exceed 6 months. The contents of the petition shall conform to the provisions of subsections (*a*) and (*c*) above. Notice of the petition for the extension of placement shall be made in conformity with subsection (*e*) above. The court shall hold a hearing to determine whether to renew the order. Any person entitled to a notice under subsection (*e*) above may appear at the hearing and challenge the petition; in this event, the court shall conduct the hearing pursuant to the provisions in section 12 of this act.

(*k*) Transfer.—The residence of an elderly person which has been established pursuant to an order for protective placement shall not be changed unless the court authorizes the transfer of residence after finding compelling reasons to justify the transfer.

(*l*) Temporary placement.—When an elderly person lives with his guardian, the guardian may petition the court to order an alternative temporary placement of the elderly person for good cause, such as to allow the guardian to take a vacation or to release the guardian temporarily for a family emergency. Such placement may be made for not more than 18 days, but the court may grant upon application an additional period not to exceed 30 days. The petition shall include such information as the court deems necessary and adequate. In ordering the alternative placement, the court shall provide for the least restrictive placement consistent with the needs of the elderly person and comparable to his previous residence. Petitions for alternative temporary placement shall not be granted more than once a year except in an emergency.

(*m*) Discharge from placement.—Prior to discharge from protective placement, the Geriatric Evaluation Service shall review the need for continued protective services after discharge, including the necessity for a conservator or guardian. Such recommendation and report shall be made to the Department, the public guardian, the elderly person's conservator or guardian, all persons notified of the original petition for protective placement, and the court where appropriate.

(*n*) Duties of the guardian.—A guardian of an elderly person placed under this section shall have the duty to take reasonable steps to assure that the elderly person is well treated, properly cared for, and provided with the opportunity to exercise his legal rights.

(*o*) Confidentiality of records.—Any records of the Department or other agency pertaining to an elderly person who is protected under this act or for whom an application has ever been made for such protection are not open to public inspection. Information contained in such records may not be disclosed publicly in such a manner as to identify individuals, but the record shall be available upon application for cause to persons approved by the court.

(*p*) Voluntary request for placement.—Any elderly person may request protective placement under this act. No legal rights are relinquished or modified as a result of such placement.

(*q*) Costs of placement.—The costs of providing protective placement shall be borne by the elderly person, unless he is placed in a public facility or is eligible for assistance under Federal or State programs, or the facility is willing to provide placement without charge.

Comments on section 11

An involuntary change of residence of an elderly person to an institutional setting, or from one institution to another, often produces major effects in the person's physical and mental health as well as in his civil rights, and therefore special proceedings to authorize such actions are necessary. The degree of incapacity required to justify protective placement as compared with protective services is greater, in that for the former the person must be found to be incapacitated to the extent that appointment of a guardian is justified. The definition of an "incapacitated person" in subsection (*a*)(1) is presented in the alternative to permit a jurisdiction with a different definition in its guardianship laws to utilize that definition in lieu of the one offered in section 3(10) of this act. The other findings required in subsection (*a*), particularly as to the gravity of the person's disability and its consequent risk of harm to others or himself, again emphasize that orders for protective placement should be given only when a solid justification for such action has been established in court.

The procedural provisions of subsections (*c*), (*e*), and (*j*) generally follow those discussed earlier under section 10 for emergency orders for protective services. Because the order for protective placement requires a finding that the person is incapacitated, subsection (*d*) requires that the accompanying petition for appointment of a guardian be heard and decided first, in that such appointment includes a finding of incapacity.

The role of the geriatric evaluation service has already been discussed under section 7.

Subsection (*h*) requires the court to consider the preference of the elderly person himself for placement, even though by definition he has refused consent to such action. This section may not be used as a vehicle to avoid the State's civil commitment law, and therefore the court may not authorize placement in a mental hospital.

Orders for protective placement are only temporary; that is, 6 months in duration, under subsection (*i*). The burden to obtain renewal of the order is placed by subsection (*j*) on a party other than the elderly person. If no such party seeks renewal, the elderly person is free to leave the residence established by the last court order. To obtain renewal of the order, the petitioner must file a petition similar in form to that previously filed and notify the persons previously entitled to notice. The court's hearing on the petition for renewal, however, may be of an ex-parte nature unless the elderly person himself or any other party entitled to notice desires to contest the petition. In this event, a hearing pursuant to section 12 must be held.

Subsection (*k*) places an additional burden of justification on a petitioner who wishes to transfer again the residence of a person who has already experienced displacement as a result of an order for protective placement. This provision is designed to prevent transfers of "convenience" intended to benefit the provider or the petitioner rather than the elderly person.

Subsection (*m*) requires the geriatric evaluation service to evaluate the person's need for assistance if discharge from protective placement occurs. The GES' recommendations are intended to assist the guardian or conservator in caring for the person or his property. If the guardianship or conservatorship is also terminated upon discharge, then the elderly person is free to accept or not the GES' recommendations.

Subsection (*n*) emphasizes that a guardian of an institutionalized person has a special responsibility to monitor the care and treatment of this person. If this care and treatment prove deficient, the guardian should exercise the remedies provided by Federal or State law.

Unlike section 6(*d*) which placed initial responsibility for the costs of protective services on the provider, subsection (*g*) makes the elderly person himself primarily responsible for the costs of protective placement. This principle is consistent with current Federal and State law concerning institutional care of the elderly. The alternative of making the institution responsible without providing for reimbursement would create insurmountable difficulties and nullify protective placement except for those eligible for governmental assistance.

SECTION 12. Hearing on petition.

(*a*) Hearing procedure.—The hearing on a petition for an emergency order for protective services or for an order for protective placement shall be held under the following conditions:

(1) The elderly person shall be present unless he has knowingly and voluntarily waived the right to be present or cannot be present because of physical or mental incapacity. Waiver or incapacity may not be presumed from nonappearance but shall be determined on the basis of factual information supplied to the court by counsel or a visitor appointed by the court.

(2) The elderly person has the right to counsel whether or not he is present at the hearing, unless he intelligently and voluntarily waives the right. If the person is indigent or lacks the capacity to waive counsel, the court shall appoint counsel. Where the person is indigent, the State shall pay reasonable attorney's fees; that is, such compensation as is customarily charged by attorneys in this State for comparable services.

(3) The elderly person shall have the right to trial by jury upon request by the person or his counsel.

(4) The elderly person has the right at his own expense, or if indigent at the expense of the State, to secure an independent medical and/or psychological or psychiatric examination relevant to the issue involved in any hearing under this section, and to present a report of this independent evaluation or the evaluator's personal testimony as evidence at the hearing.

(5) The elderly person may present evidence and cross-examine witnesses.

(*b*) Duties of counsel.—The duties of counsel representing an elderly person for whom a petition for an emergency order for protective services or for an order of protective placement has been filed shall include: personally interviewing the elderly person; counselling the person with respect to this act, his rights, and any available alternative resources or causes of action; arranging for an independent medical and/or psychological or psychiatric examination of the person relevant to the issue involved in the hearing; and providing competent representation at all proceedings.

(*c*) Statement of findings.—The court shall issue for the record a statement of its findings in support of any order for emergency protective services or protective placement.

Comments on section 12

Subsection (*a*) sets forth the basic procedural rights of the elderly person at hearings on petitions for an emergency order for protective services or an order for protective placement. In some details these provisions are more protective of the person than many State laws concerning guardianship and conservatorship, or even the Uniform Probate Code itself. This added protection appears warranted by the substantial deprivation of personal liberty which may be the outcome of these hearings.

If anything, those States should consider strengthening the procedural rights of parties who are the subject of guardianship and conservatorship proceedings to emphasize the fact that such proceedings are at root adversarial in nature, and rightly so, and therefore the paternalistic undercurrents of many older laws should be abandoned. The rights and interests of all parties to these proceedings are best preserved when proceedings are truly adversarial.

The right to counsel provided in subsection (*a*) (2) is of special importance in these proceedings. Waiver of the right is permitted, but the court should exercise caution in concluding that the person is waiving this right, because the petitions in these cases may be based on allegations of mental incapacity of the person to make responsible decisions. If these allegations are taken at face value, then a waiver of the right to counsel may be subject to the same incapacity.

This subsection and subsection (*a*) (4) require the State to afford the indigent elderly counsel and professional evaluations at public expense. Counsel might be provided through legal aid or legal services offices or by the Public Defender. In appointing counsel the courts should be sensitive to their responsibility to appoint as counsel, where possible, attorneys with special competence or expertise in mental health proceedings.

Subsection (*b*), by listing in detail some of the duties of counsel, is intended to avoid permitting attorneys to provide only pro forma representation similar to that given by the guardian ad litem in many jurisdictions.

SECTION 13. Duty to report.

(*a*) Nature of duty.—Any person having reasonable cause to believe that an elderly person is infirm, incapacitated, or in need of protection shall report such information to the Department or the public guardian.

(*b*) Procedure for reporting.—The report may be made orally or in writing. It shall include the name, age, and address of the elderly person; the name and address of any other person responsible for the elderly person's care; the nature and extent of the elderly person's condition; the basis of the reporter's knowledge; and other relevant information.

(*c*) Immunity.—Any person making a report pursuant to subsection (a) above, testifying in any judicial proceeding arising from the report, or participating in a required evaluation, shall be immune from civil or criminal liability on account of such report, testimony, or participation, unless such person acted in bad faith or with a malicious purpose.

(*d*) Action on report.—Upon receipt of a report, the Department shall make a prompt and thorough evaluation to determine whether the elderly person is in need of protective services and what services are needed, unless the Department determines that the report is frivolous or is patently without a factual basis. The evaluation shall include a visit to the person and consultation with others having knowledge of the facts of the particular case. After completing the evaluation, the director shall make a written report of his findings to the elderly person, his spouse or next of kin, and the person making the report.

If the director determines that the elderly person needs protective services according to the criteria set forth in section 10(*a*) of this act, the director, the elderly person, his spouse or any interested person may petition the court for an emergency order for protective services pursuant to section 10 of this act.

Comments on section 13

Subsection (*a*) imposes a duty on all citizens to inform the State agency or the public guardian of the status of persons who are believed to be infirm, incapacitated, or in need of protection. No penalty, however, is imposed on one who fails to make such a report. Subsection (*c*) authorizes immunity from civil or criminal liability for persons making a report, except where the reporter acted in bad faith or with a malicious purpose, such as intent to harass the elderly person or to force the person to undertake a transaction against his will. The State agency is expected to investigate all such reports unless it finds that the report is frivolous or clearly without a basis in fact.

SECTION 14. Right to appeal.

An elderly person, his conservator or guardian may appeal any findings of a court under sections 10(*a*), 11(*a*), 11(*j*), or 11(*k*) of this act. Such appeal shall be handled on an expedited basis by the appellate court.

Comments on section 14

The provision for an explicit right to appeal particular findings of a court is consistent with the act's philosophy that the proceedings authorized under it be truly adversarial and that the findings of courts be specific and based on clear evidence.

SECTION 15. Severability. (Insert severability clause.)

SECTION 16. Repeal. (Insert repealer clause.)

SECTION 17. Effective date. (Insert effective date.)

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